Vol. XIX. APRIL, 1879. No. 112.

THE

AMERICAN PRACTITIONER:

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

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PUBLISHERS:

JOHN P. MORTON & CO., LOUISVILLE.

CATHCART & CLELAND, INDIANAPOLIS.

THREE DOLLARS PER ANNUM.

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THE AMERICAN PRACTITIONER.

APRIL, 1879.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else.—RUSKIN.

Original Communications.

GALVANISM IN THE TREATMENT OF SCIATICA.*

BY V. P. GIBNEY, A. M., M. D.

Of the Hospital for the Ruptured and Crippled, New York.

CASE X.—*Four months' standing; an intercurrent arthropathy; cure.* J. R., male, aged eighteen years, had been suffering from a sciatica four months, when he made application at the out-door department for relief. This was on September 20, 1877. The limb felt cold, was dull and heavy. The sharp attacks of pain had no influence in bringing warmth to the limb. A current of moderate strength (eighteen cells) gives relief.

21st. Free from pain all day yesterday, and slept well all night. A stronger current (twenty cells) is employed this morning, and immediately he exclaims, "My limb *feels warm.*"

22d. Better in every respect. The limb is not so cold at night now as it formerly was.

24th. Has no more sharp pain, and expresses himself as improving daily.

25th. Yesterday had a few light attacks, which soon passed off; had none through the night. The current is used whenever he calls, *i. e.*, when the notes are made.

*Continued from March No., page 180.

26th. Only a mere tingling sensation is felt about the hip. The limb continues to feel warm, and there is scarcely any lameness. Recently a swelling about the ankle, same side, has made its appearance, but is subsiding.

October 6th. First call since the 26th ult., and he reports that 4th inst., two days ago, he had a severe paroxysm of pain, but none since. It is noted that it rained all that day, and to this he attributes his apparent relapse. Another application.

10th. Pain only on getting into and out of bed, and on suddenly twisting the limb. The condition of ankle is better. Further details are unimportant. It is enough to know that one or two more applications were made, and on December 8th he was discharged cured.

It will be noted, in passing, that I am making no observations on the pathology of neuralgia of the sciatic. Lack of space forbids, even had I any observations to offer. If one read that delightful little book of Dr. Anstie, to which I have already referred, one feels it presumption on his part to offer suggestions, even as to a pathology so little of which can be set forth in the form of the tangible. I am likewise unwilling to consume time with theories as to etiology, thinking that clinical facts are far more valuable; and with this idea before my readers, the object in relating so many cases in detail can be fully appreciated.

CASE XI.—*Twelve months' standing; relieved after four sittings.* K. W., female, aged twenty-five years, came under treatment May 2, 1878. The right sciatic in its distribution was the seat of severe pain, and the limb was stiff, thus causing her to walk very lame. The first symptoms began one year ago, while she was occupying a damp basement floor. The disease has not given much anxiety until within four months, and it is only within the past four weeks that her sufferings have become so great. This morning a strong current is applied for about five minutes, and is followed by immediate relief.

3d. For an hour yesterday there was absence of pain, but it returned with as much severity as ever. Is relieved by a strong current this morning.

4th. Has had less pain, and feels every way better. Pain is only induced by walking, and then is light. A five minutes' sitting.

6th. Improvement marked. Reports herself as free from pain. Patient did not return again, and my efforts to trace the case proved fruitless.

CASE XII.—*Four months' standing; a distal branch of the sciatic the only exception to an established cure; this neuralgia not treated.* B. V., Pole, aged forty years, an ironer by occupation, came under observation December 10, 1877. His first symptoms came without known exciting cause during the summer preceding. The right limb was the one affected, and the usual history as to progress is obtained. He has found most ease in the sitting or recumbent posture. As a rule he sleeps well. It is only by day, as he is standing all the while, that the pain becomes so agonizing. A strong current this morning.

11th. Reports that he had no pain during the greater portion of yesterday, and that the little he did have was comparatively light. Repeat the application.

12th. Worked all yesterday afternoon; this morning the pain returns. A strong current with immediate relief.

13th. As an experiment the ether spray is used instead of the galvanism, and there is no relief.

15th. Was not present yesterday, and had pain all day. The weather was damp, however. A mild current gives relief.

17th. A current of medium strength, though he has had very little pain since the 15th.

19th. Occasional pains, though robbed of their severity. Now refers pain to the calf, while it has heretofore been in thigh and nates. The negative pole is placed over calf, with positive over main trunk; perfect relief.

22d. Condition same as date of last note. A current of medium strength.

February 2, 1879. He did not call again, but I saw him to-day at his home, and I found him free from pain about hip, thigh and knee since December 22, 1877. He has worked all the while. There is, however, an occasional pain below the calf, but this does not annoy him enough to make him seek advice.

This man worked all the while, even when under treatment. There is no reason why a permanent cure should not

have been wrought. The current was probably not strong enough; besides the sittings were not of sufficient length: these we were taking only about five minutes. Further experience has taught us that for old cases ten or fifteen minutes must be the rule. If he could have come daily, it would have been better. The ether spray seemed to have been of no value whatever.

CASE XIII.—*Six months' standing; cure and no relapse after eight months.* J. D., a coachman, aged thirty-four years, applied February 21, 1878, with a history of sciatica dating from a period six months ago, and with the first symptom a pain in the knee. The right side was the one affected. This pain gradually extended to neighboring parts. He knew of no cause. For three months he has suffered so much that he could do no work, and the lameness has been such as to prevent him from attempting to go about. He suffers more acutely toward night, and comes to-day with the usual story about the quantity of medicine consumed. A strong current is applied for about eight minutes.

28th. To-day a *very* strong current is applied, this being the fourth sitting, and he is enthusiastic in the expression of the relief he has obtained.

May 3d. Calls to report that he is well; feels perfectly restored.

6th. Has a little pain on moving the limb. A strong current applied. He did not call again, but on January 20, 1879, I learned from his wife that he had been free from pain or lameness since last spring; that there had not been the first symptom of a relapse; was attending to his work without any interruption, and that he had grown hearty and robust.

CASE XIV.—*Three weeks' standing; cure with no relapse after eighteen months.* T. B., a fireman, aged twenty-five years, came under the galvanic treatment May 4, 1877. Three weeks prior to this date, while shoveling coal, experienced a sharp pain down the thigh and calf, right side. There had been no extra strain, and no previous exposure. He suffered terrible pain that night, and for four days thereafter was confined to his bed, the least movement adding to his torture. The usual history of paroxysms is present, and at night the suffering is more intense. The thigh is with difficulty extended to the normal limit, and flexion is resisted with about

equal force. The pain is referred to the gluteal region over the sacro-sciatic notch, down posterior surface of the thigh to popliteal space, and down calf to heel. The family history is negative, and the patient himself claims to have always been healthy, though his appearance would seem to contradict the statement. He walks into the office bearing most of his weight on a cane, and can only walk short distances even thus supported. The positive pole is placed over the lumbar spine, and the negative over the site of the nerve at its exit, both being pressed firmly into the soft parts, and a strong current is employed for five minutes.

26th. Has had applications daily for a week or more, then every three or four days, and is so much relieved that he walks without a cane, and with very little trace of lameness. The pain has almost entirely disappeared.

June 5th. Experiences pain only on rising from bed, and on taking a false step. A slight degree of stiffness is present, though not enough to interfere in the least with walking. He obtained work and did not return.

January 10, 1879. Called at his house and learned from him that he had been working steadily since the summer of 1877, without the least discomfort; that he has no pain or tenderness in his limb now, and has not had any for eighteen months; and that the only reminder he ever has of his former disease is an occasional sense of fatigue in the limb after excessive work.

Dr. Anstie, on page 252 of the work already twice mentioned, says:—"In the first place, I have arrived at a decided conviction that faradic electricity is of little or no value in true neuralgias; and that the cases which are apparently much benefited by it will invariably be found, on a more careful investigation, to belong to some other category."

My own experience, if it were recorded, would coincide, word for word, with the paragraph just quoted. I have seen the faradic current used by men who had attained some proficiency in the application of electricity, and I could report the cases now in full did space permit. I shall be pardoned, I know, for introducing the following and concluding case, so well does it illustrate this very subject; and I shall forbear making reference to other authors in substantiation of what Dr. Anstie has so well said.

CASE XV.—*Seven years' standing; restoration to use of limb in two weeks; substitution of faradic for galvanic current, and speedy relapse.* On the 6th of November, 1878, there was brought into the office a German woman of enormous size, aged fifty-one years. Her son and a neighbor had with great difficulty succeeded in bringing her from the carriage into the building. The history, as given by the patient and corroborated by the son, was that she had not walked alone for nearly six years; that she had, seven years ago, a kind of muscular rheumatism, no joints having swelled, and now no crepitation is imparted to one's hand when placed over her joints in motion; that soon after these pains she began to suffer most acutely about the right hip, and down the thigh even to the ankle, the pains becoming paroxysmal and intolerably severe; that she gradually became inured to suffering, and the pains seemed less severe; that during the past few months a constant, dull, aching pain is that which gives the most annoyance. The paroxysms are still present, though modified. The patient herself was not in want, and it is reasonable to infer that medication, internal and external, has been well nigh exhausted. Having despaired of relief in this country, she went to Germany for the various baths, and after spending nearly a year without decided relief she returned.

An examination is made, and the limb found much atrophied, especially along the course of the main trunk of the sciatic, where there is a groove-like depression extending from the upper third of the thigh to the middle of the popliteal space. The thigh is flexed on pelvis, and leg on thigh, so that the foot rests on the toes merely. There is marked paresis, the patient not being able to raise the limb when she is in the recumbent posture. Deep pressure over the trunk of the nerve at its exit causes a little tingling in the distribution of the same, though there is so much adipose that this test is unsatisfactory.

What to do with such a case I was at a loss to decide. I actually feared that a current could not reach the nerve buried behind so much adipose. I did not see how she could come back and forth for daily applications. Finally I told the son that if he would bind himself to secure a carriage by the week, and bring the patient up every morning (Sundays excepted) for four weeks, we would undertake the treatment of the case, and let the patient have at least the benefit of the doubt. They went home to consider the question, and on the 11th she returned, ably escorted. Dr. Horst, who had

charge of the electrical room, made an application of a very strong current for fifteen minutes. To the fullness of his notes, and to his faithfulness in attention on the case, I am glad in this connection to acknowledge my indebtedness. To this strong current no pain was felt—the patient was simply aware of the contact.

12th. Current of same strength, and sitting of same duration, with like result.

13th. This morning there is marked improvement. She is able to stand alone, with *both feet squarely on the floor, and walk a few steps without assistance.* She is also able to raise the limb, declaring that this morning while in bed she held it up voluntarily about two minutes (emphatic about the time). Sensation has very markedly improved. This was also observed yesterday morning, though to a less degree. The same current to-day produces considerable pain, and when the current is interrupted she feels a sharp pain extend to the foot.

22d. Has been attending daily as directed, and the sittings have been from ten to fifteen minutes long. For the past few days she has been able to go up and down stairs—something she has not been able to do for five years or more. Is able to get into and out of the carriage unassisted. Has regained considerable voluntary power of the limb. Pains much diminished, though not completely dissipated.

25th. The weather is changeable to-day, and she complains of much pain. 26th—ditto.

27th. Feels remarkably well; walked alone from the carriage into the office.

29th. Much pain this forenoon, and the weather is inclement.

Dec. 2d. Has dismissed the carriage, and comes up in the street car. Is free from pain this forenoon, and feels well, although the weather for the past day or two has been damp and variable.

3d. Much pain this morning. Yesterday walked two blocks without any assistance. The thigh is increasing in size, and is gaining much strength. She did not come again, and on inquiring into the cause, I learned that she had been advised by a physician to purchase a faradic machine—"a battery for herself,"—have it applied at home every day, and thus do away with the necessity of coming up to the hospital. Accordingly she bought a small battery.

February 2, 1879. In looking up our cases I visited this patient,

and found her seated in a large arm-chair, *hors de combat*. She was scarcely able to get about, and her pains had returned. She had been using the faradic current until the battery got out of order. It had made her notably worse, and she feared to come back to the hospital lest she would not be received again for treatment.

This is suggestive enough, and comment is unnecessary.

It was my intention to report a few cases of sciatica of rheumatic origin, wherein both currents had been tried; but already my paper is longer than I had expected to make it, and I must content myself with giving the result of my observations. I believe that in neuralgias of rheumatic origin, the symptoms are, as a rule, aggravated by the galvanic current and benefited by the faradic. Even in symptomatic neuralgia, we have obtained much relief from the constant current; still it has been used with more caution here, and the treatment has been as a matter of course a mixed treatment. All of the cases of sciatica which I have reported in this paper had no medicine whatever. In the first place, the majority of the patients were unable to buy any; and in the second place, it was my aim to give the constant current a fair test. We have still a number under observation whose histories would but confirm overwhelmingly the results herein reported; but as sufficient time has not elapsed to study the question of relapse, I have retained them for a future report. Dr. Josselyn, of the hospital, is now treating several cases with the most happy immediate result.

One word with regard to the strength of the current we employ. In some instances not only has a lively erythema been observed around the electrode, but on removing the same there is occasionally seen (in two patients) an eschar. We have never found any bad effects follow currents thus strongly employed. The chief objection urged by electrotherapeutists to such a current, is the injury it may do neighboring viscera. In the treatment of sciatica after this method we have no viscera sufficiently neighborly to be affected; yet I want to be understood as appreciating fully the value of this objection.

RÉSUMÉ.—Fifteen cases were treated, and eleven of this number were cured, only one of which relapsed at the end of eight months under strong provocation. The remaining ten have not relapsed up to the present time.

Four of the fifteen treated were greatly relieved, but the relief was not sufficiently prolonged as to predicate of all a cure; still in two of the cases a cure of the sciatica seems to have been established, although a little stiffness remains as a remnant of the disease.

One case was of three weeks' standing, and was under treatment twenty-three days, with thirteen applications—the first six during the first week, the remaining seven at irregular intervals in the seventeen days following. *Result*,—cure and no relapse at the end of eighteen months.

One was of six weeks' duration, under treatment nine days, with eight applications. *Result*,—cure and relapse, with sufficient cause, at the end of eight months. Did not apply again for treatment, as the symptoms were not severe enough to justify him in giving up his work.

Two were of three months' duration: one, under treatment thirteen days, receiving six applications of the current, *resulting* in a cure, with no relapse at the end of eleven months; the other under treatment seven days, with five applications, and *resulting* in a cure, with no relapse at the end of eleven months.

Four were of four months' standing. The first, under treatment twelve days, eight applications, with a *result*,—cure, and not heard from in fourteen months. The second, under treatment twenty four days, eleven applications, with a *result*,—cure, and no relapse at the end of ten months. In this case there was an interim of eight days in which an intercurrent affection was treated. The third, under treatment sixteen days, seven applications, with a *result*,—cure, and no relapse after sixteen months. The fourth, under treatment thirty-eight days, sixteen applications, with a *result*,—cure, and not heard from in fifteen months.

One was of eight months' duration, but the number of ap-

plications is not recorded; at all events not more than six were made. *Result,*—cure, and no relapse at the end of eighteen months.

Two were of one year's standing. One under treatment twenty-five days, twelve applications, with a *result,*—greatly improved and practically cured. The treatment in this case was interrupted. The patient was heard from at the end of twelve months, and there had been no return of the acute symptoms. He is now attending to his work every day. The other, under treatment five days, four applications, with a *result,*—almost a complete cure; unable to find the present whereabouts of the patient, and ultimate results hence not obtained.

Two were of three years' duration. The first was eighteen days under treatment, twelve applications, with a *result,*—cure, and no relapse at the end of thirteen months. The second, under treatment four days, four applications, with a *result,*—temporarily relieved, but relapsed, and now suffering as severely as ever.

One was of five years' standing, and received about ten or fifteen applications—number not recorded. The *result,*—cure and no relapse at the end of ten months.

One was of seven years' standing, under treatment nineteen days, receiving fifteen applications. *Result,*—relief (see Case XV) to a remarkable degree; then a speedy relapse under the faradic current, which was used without our knowledge.

Conclusions.—The practical deductions to be drawn from the foregoing cases are simple enough. With a galvanic battery the practitioner has under control one of the most obstinate and harassing of maladies. Under his observation come all the recent cases, and with a practical knowledge of the constant current the neuralgia could be arrested before it becomes chronic, and at a stage of all others the most amenable to a judicious electrical treatment.

The battery need not be an expensive hospital battery. The ordinary Stöhrer, consisting of from eighteen to thirty-

two elements, would answer all purposes. In some of our cases, a small portable battery, manufactured by M. Boissier, of New York, has been used. This is a very simple apparatus, and possesses the advantage of being kept easily in repair.

So far as the direction of the current is concerned, I believe, with many others, that it makes little difference, though I have no cases recorded in which an ascending current was employed. From clinical experience I would advise the descending current. In our earlier cases we placed the positive pole over the lumbo-sacral region, and the negative over seat of pain. Latterly we have placed the positive over trunk of nerve at its exit, and negative over seat of pain.

It is best not to move the sponges from place to place during one sitting: the contractions which follow the breaking of the current prove too irritating to the nerve. If the pains are diffuse, it will be better to reach the distribution of a distinct branch at a single sitting. Next morning another branch can be embraced in the circuit. The sitting should vary from five to fifteen minutes, ten minutes being that in which the best results will be obtained.

NEW YORK CITY.

FOREIGN BODIES IN THE AIR-PASSAGES.

BY G. B. PRATT, M. D.

Late Resident Physician of the Kings' County Hospital, Brooklyn, N. Y.

A recent number of the London Lancet contains a report of a lecture delivered by George Johnson, M. D., F. R. S., on the above subject. He cites quite a number of curious cases of foreign bodies having lodged in the esophagus, larynx, trachea and bronchi, and gives the method adopted in each instance for their removal, closing with some general remarks on the physical signs, diagnosis and treatment of foreign bodies in the air-passages.

A perusal of this report has recalled to my mind several cases of this troublesome, and oftentimes very alarming accident, which have occurred in my own experience. It is not my intention, nor is it the object of this paper, to give a report of these cases, but to present to the consideration of medical men two important suggestions bearing on this subject.

I. The first thought to which I would direct attention is *the necessity of laryngoscopic examinations* in all cases, where the presence of a foreign body is suspected, or at all suggested, by the existing symptoms, unless the symptoms should be too urgent to admit of delay. Any one familiar with the anatomy of the throat, is aware that a morsel of food, or a small article, as a button, may so lodge in this vicinity as to be out of reach with the finger, and out of sight by simply looking in the mouth, when the laryngoscope would reveal its situation at once.

Many lives have undoubtedly been lost through the neglect of this means of diagnosis, chargeable in many instances to thoughtlessness, and in not a few to ignorance, on the part of the attending physician.

In illustration I will quote from Dr. Johnson the following case:—"An elderly man, an inmate of a prison, suddenly fell down while at dinner, and was supposed to be in a fit. When the surgeon arrived he found the man blue in the face, and breathing stertorously. Suspecting that there might be some foreign body in the throat, a probang was passed, and it was thought that something had been pushed down the gullet. The symptoms continued, and the man died in the course of the afternoon. After death a piece of tendon of meat was found under the epiglottis." Here the laryngoscope might have shown the true cause of the symptoms.

A somewhat similar case occurred in my hospital practice. I was summoned in great haste to see a man about sixty years of age, who had "fallen in a fit" while eating dinner. I found him lying on the floor just as he had fallen from his bench, his face livid, eyes prominent and staring, mouth wide

open, and head thrown back. He stopped breathing as I entered the ward; his pulse, however, was still faintly perceptible. Thinking he might have choked on some particle of food, I thrust my fingers as far as possible down his throat, but could feel nothing. Not being satisfied with this effort I seized his tongue with a napkin, and drawing it as far forward as possible, passed my finger down on one side and succeeded in dislodging a large piece of meat. The man immediately drew a deep inspiration, and in a few moments was feeling comfortable. In this case there was no time to be lost, and an examination with the laryngoscope was out of the question.

Large bodies lodging in the throat can often be felt by the finger or seen by looking in the mouth; not so in the case of small articles, as pins, needles, fish-bones, etc. But these may be readily perceived by the use of the laryngoscopic mirror, and removed with forceps. And in certain favorable cases, even when the foreign body has lodged in the larynx, especially the upper portion, it may be seized with a pair of laryngeal forceps, under guidance of the laryngoscope, and withdrawn.

Pieces of coin may be sucked from the mouth, by a sudden inspiration, and fall upon the glottis in such a manner as to almost entirely occlude the opening, leaving but a small space through which air may enter the larynx. In Dr. Sanderson's interesting case,* a man holding a sixpence in his mouth, while laughing suddenly fell to the floor suffocated. He rallied, however, and for two months went about his ordinary business, being attacked occasionally by fits of coughing and dyspnea, and at no time able to speak above a whisper. At the end of this time he was one day seized with a feeling of suffocation as urgent as immediately after the accident. As soon as possible after this, his throat was examined with a laryngoscope, and the coin was at once seen lying flat across the glottis, the edge in the ventricle on either side. There was a breathing space behind the edge of the sixpence, between the arytenoid cartilages. Numerous attempts were made to

* Medico-Chirurgical Trans., Vol. 48.

dislodge the coin by holding the man's head downward, and slapping the back of his neck. This not succeeding, bent loops of wire were prepared for the purpose of jerking it out. But tracheotomy was finally resorted to, and the foreign body pushed upward. The man speedily recovered.

Sir Thomas Watson speaks* of a very similar case occurring in the practice of Mr. Henry Smith. A man while intoxicated put a half sovereign in his mouth, which immediately slipped into his larynx. The symptoms were pain in the larynx, a feeble husky voice, stridulous breathing, and cough with copious expectoration. A laryngoscopic examination discovered the coin lying flat upon the vocal cords. It was removed by the same procedure resorted to in Dr. Sanderson's case.

Druitt† says:—"The use of the laryngoscope is twofold; in diagnosis, and for the application of remedies. It reveals the presence of foreign bodies. By its use these troublesome intruders may be seen, seized and extracted." And Flint,‡ in writing on this subject, remarks that "the laryngoscope may be said to have, in a great measure, transferred the interior of the larynx from the domain of medicine to that of surgery, by rendering this part open to inspection. The presence or absence of foreign bodies may by this means be ascertained."

Dr. Cohen§ writes:—"The laryngoscope has, in the most literal sense, thrown light upon many an obscure condition which would otherwise have remained unrecognized, and have been liable to misinterpretation in the gloom of subjective investigation alone."

The following case, in which the laryngeal mirror was used with advantage, is an example of what might happen to any practitioner who neglected using this method of examination. A fine healthy boy, aged a year and eight months, was taken to Dr. Johnson by his parents, who said that two days before

* Watson's Practice of Physic, p. 275.

† Surgeon's Vade-Mecum, p. 464.

‡ Flint's Practice of Medicine, p. 269.

§ Diseases of the Throat, p. 12.

he had swallowed a copper penny. At the time of the accident he was black in the face; his eyeballs apparently starting out; and he seemed in immediate danger of suffocation. On the arrival of the medical attendant, these symptoms having somewhat subsided, he supposed that the coin had passed into the stomach. But as the child was unable to swallow solids, and the swallowing of liquids was attended with difficulty and excited coughing, the father became anxious and consulted Dr. Johnson. On the introduction of a small laryngeal mirror, the coin was seen sticking in the upper part of the esophagus. With a pair of long, slender, curved forceps, guided by the throat mirror, the penny was seized and extracted. Had this been allowed to remain, there is no doubt but death would have ensued from the extension of inflammation and swelling to the larynx.

Cases illustrative of the necessity of making laryngoscopic examination might be multiplied, but I think enough have been given to direct the attention of every thoughtful reader to this point. Setting aside the question of foreign bodies in the air-tubes, it is impossible for any one to treat affections of those passages skillfully and intelligently without the aid of such valuable suggestions as to diagnosis and treatment as are rendered by the laryngeal mirror. Therefore it is incumbent upon every practitioner to supply himself with the necessary apparatus (the cost of which is not great), and become conversant with its use. The best and readiest method of obtaining skill in the practice of laryngoscopy, is by acquiring facility in the examination of one's own larynx.

II. Although the following remarks are in reality a continuation of the same subject, my desire is to call attention to the great danger attending the practice so common among general practitioners, of passing a probang down the gullet, with the intention of crowding the foreign body, if any there be, into the stomach, without first using the laryngoscope to determine the nature and position of the offending particle, with a view to its removal if possible. It is true some of the

text-books advise this procedure. Thus Sir William Fergusson* writes:—"In certain instances, when a foreign body is known or supposed to be in the gullet, the best practice may be to push it down altogether with a broad-pointed bougie." But this was written before the introduction of the laryngoscope into the practice of medicine and surgery.

Dr. Cohen† mentions a singular case. He was called in consultation to see a man with chronic hoarseness of several months' standing. The story was that, about a year or rather previously, the patient had swallowed, during his sleep, a gold plate to which a false tooth was attached. The physician who was called in to the case felt the foreign body with his finger, and, failing to extract it, pushed it forcibly into the stomach. The patient was very feeble, and unable to eat or drink, every attempt at drinking being followed by ejection of the fluid in a paroxysm of spasmodic cough. An opinion was given that a fistulous opening existed between the esophagus and trachea. A post mortem examination revealed the gold plate lodged in the esophagus opposite the bifurcation of the trachea, with a communicating opening at this point. This man's life might have been saved had the plate have been bent up with a pair of strong forceps and withdrawn.

Sir William Fergusson had under his care a woman who, two months before consulting him, had while asleep displaced four false teeth which lodged in her throat. The doctor summoned, at once endeavored to push the teeth down the gullet by a bougie, and repeated the attempt day after day. Sir William found the mass impacted at the lower extremity of the esophagus, and was unable to remove it. No doubt the foreign body might have been readily removed when in the upper part of the gullet, had not the doctor's first thought been to *push it down.*

Dr. Johnson‡ says, in this connection:—"When a foreign body in the throat can be seen or felt, and reached from

* Practical Surgery, p. 651, 1852.

† Diseases of the Throat, p. 233.

‡ London Lancet, January, 1879, p. 2, Am. reprint.

above, an endeavor should be made to extract it, and not at first to push it down."

Dr. Cohen writes as follows (p. 237):—"When the foreign substance is one susceptible of digestion, and can not be removed by instruments, it may safely be pushed down into the stomach by means of a stout probang armed with a moistened sponge." He mentions a case in which a copper halfpenny had been swallowed by a child of five years of age. It was forced into the stomach. Enteritis followed, resulting in death. After citing several other cases, he says:—"Many other cases of similar nature are on record, showing the necessity that exists for making due attempts to extract a foreign body from the esophagus."

ELKHART, IND.

DO WE EVER CURE SYPHILIS?

BY C. A. BOYCE, M. D.

I know of no question which is more pertinent than the above, and upon which, in many instances, hangs the destiny of the children of thousands of families. I fear that physicians have not attached the importance that they should to the answers that they give in many cases to patients in regard to the possibility of their being still uncured, and liable to transmit syphilitic disease to their children in the event of matrimony. How often is it that a young man comes to his physician and tells him that he contemplates marriage, and wants to know if there is any chance of his having syphilis in his blood—wants to know if he will transmit the trouble to his children. Many more will come and tell the doctor to take them through a course of medicine, to get them purified and ready to marry. The responsibility is great, indeed, upon the doctor who gives a decided and unreserved opinion

in favor of any man's perfect cure after once exhibiting plain evidences of constitutional disease.

A great deal may be said on both sides of the question, and many cases may be referred to in which no return of symptoms have been seen after a lapse of considerable time; we must not, however, confound latency and eradication of a disease. Look at the children of consumptive parents, in whom the latent tubercular diathesis remains undeveloped for years and years, until the adventitious moment arrives, and they have been feeding their destroyer and warming it into life in their own bosoms, if I may use the expression.

Now the most provoking thing imaginable is to follow a writer who has no opinion of his own, but tells you what everybody else thinks, and keeps quiet himself. In the present instance I am "on the fence" myself, and I hope some of my medical friends will assist me to one side or the other. However I will state that, as near as I can come to the matter, I am strongly inclined to the belief that well developed constitutional syphilis *is never cured.*

My reasons for this belief are possibly shared by the great majority of the profession. They are based upon the general impress made upon the system by constitutional disease, the transmissibility of syphilis for generations, and the reappearance of symptoms from time to time when the disease has seemed to be cured. The occasion does not require that I should dwell at length upon these facts. I will only cite an example told to me at this time by a gentleman who is an old and experienced practitioner of this city; similar cases are, however, familiar to us all. He says that, many years ago, he was called to see a woman who had very severe syphilitic ulceration of the throat. He treated her with corrosive sublimate, etc.; she was apparently well in a month. Five years after he was called to see her again, and found the disease had made its appearance again, this time attacking and destroying the septum of the nose. Treatment mercurial, with apparent cure. Fifteen years after he was called to see the same party; this time she was troubled with a large and painful node on

the left radius. Mercury again (iod. potass. and iodine inunctions) relieved her. In the case related, the doctor thought on two occasions that his patient was cured; and even a lapse of fifteen years was not sufficient time to prove the case.

The practical point aimed at in this paper is *to come to a decision in regard to the facts of cure in syphilis*, so as to be able in great measure to stop hereditary syphilis by our counsel and advice. I am sorry to say that it is one of the few constitutional diseases upon which the physician is often consulted, by those contemplating marriage, to ascertain if they are still syphilitic; and it is the duty of the doctor to speak with the utmost truth in giving an answer, for he may be the cause of untold misery and suffering to the future descendents of that man. It is the physician's duty to discourage any marriage on the part of a person who labors under syphilitic infection; and who is able to say when a man has no syphilitic poison in his system, when he has once been thoroughly infected?

This is indeed a momentous question, and one which should claim the attention of the profession; for the advance and increase of the disease is so great, the methods by which it may be propagated and communicated are so numerous, and its cure so difficult and uncertain, that it is the duty of every one of us to be alive to any measure which may tend to eliminate so terrible a plague from our midst.

RICHMOND, VA.

LECTURES ON THE SURGERY OF THE FACE.*

BY FRANCIS MASON, F. R. C. S.

Surgeon and Lecturer on Anatomy at St. Thomas's Hospital; Hon. Fellow of King's College, London.

LECTURE I.—PART II.

It would be obviously impossible for me to enter into a full description of the different varieties of tumors that have been met with on the face. I can, therefore, only refer to a few which appear to possess more than ordinary interest.

Fatty Tumors.—These are rarely observed on the face, and the exemption in this region is remarkably illustrated in a case reported by M. Danez. At a post mortem examination of a man no less than two hundred and fifteen fatty growths were found in different parts of the body. The only situation that was quite free from such tumors was the face. I happen to know at the present time a gentleman who has at least sixty such tumors on the arms, legs and trunk, but he has none on the face.

The diagnosis of fatty tumors is not at all times easy, but a method has been suggested of solving the difficulty, which consists in applying ether or ice to the part, in the case of a doubtful tumor. If the growth is felt to become harder, the presumption is that the tumor is fatty.

Fatty tumors under the eyebrow have been mistaken for nævi, and a growth of this kind in the temporal region was regarded as an aneurism, for which the carotid artery was tied. Subsequently the patient died, and at the post mortem examination the true nature of the tumor was revealed. Fatty tumors are occasionally met with either in the substance of the cheek or lying immediately under the mucous membrane of the mouth. Four years ago I removed a small growth of this kind through the mouth. It was singularly non-adherent

* Delivered at the Medical Society of London, January, 1878.

to the surrounding parts, and consisted of soft fat. A tumor thus situated has been mistaken for a cyst in connection with Steno's duct, as in a case under Mr. Ward's care at the London Hospital.

Fig. 7 shows a glandular tumor in the upper lip, which I removed from a patient at the Westminster Hospital in 1868. The woman was forty-five years old, and was struck on the lip when she was four years of age. Mr. Goodhart has reported three cases of a somewhat similar character in the Pathological Transactions, Vol. XXVIII, p. 213.

FIG. 7.

FIG. 8.

Fig. 8 represents a tumor of a myxomatous character, which I took from a patient thirty-five years of age. It had been growing for about ten years, and was scarcely observable before operation, as he managed to hide it very cleverly with his whiskers.

Tumors invading the parotid region are of constant occurrence. Some of them are a mere temporary enlargement due to inflammatory effusion, as in this case [photograph shown], in which the swelling disappeared after the application of tincture of iodine and the adoption of an alterative constitutional treatment.

The more important tumors in this region, however, consist, as a rule, of mixed glandular and cartilaginous tissues, with here and there cyst formations. Such a case is shown in Fig. 9. The patient was under my care at the Westminster Hospital. The tumor commenced as a small nodule about forty years before he came under observation, and after removal weighed over four pounds.

FIG. 9.

The probability of return after removal of course depends upon the character of the tumor: for example, in some soft sarcomata recurrence takes place very rapidly, as in a case that was under the care of Mr. Barnard Holt, in which he performed two operations within twelve months. In other examples the growth increases slowly: thus, had Mr. S. Jones removed a pendulous growth from the parotid region of a patient, aged fifty-eight, who stated that twenty-eight years previously a tumor had been removed from about the same situation. Perhaps one of the most remarkable tumors of this kind was that of which I show you photographs, operated on by the late Sir William Fergusson. I assisted at the operation, and the sterno-mastoid muscle was found to be spread over the tumor, which weighed nine and a half pounds. There was considerable hemorrhage.

Apropos of hemorrhage I may add, parenthetically, that in dealing with parotid tumors it is as well, as a last step before their final removal, for the surgeon to place a ligature on the vessel supplying the growth at the bottom of the wound. Without this precaution, the vessels are apt to retract, and are not easily secured afterwards. Even tumors having apparently a distinct pedicle often bleed very freely. Thus Mr. Hussey, of Oxford, removed a pendulous growth connected with the face weighing three pounds, from a patient aged seventy-three,

and the operation was, according to the report, attended "with profuse and almost fatal hemorrhage."

It is alleged that complete extirpation of the parotid has been practiced, but, considering the anatomical relations of this organ, it seems almost impossible to effect its entire removal without serious risk to the patient. However, Dr. Valentine Mott states that the operation has been frequently performed; and M. Marzolo, an Italian surgeon, gives an account of the case of a woman, aged fifty, "from whom he had removed the entire parotid without injuring the facial nerve or the external carotid artery." Sir William Fergusson, in recording his experience on this point nearly forty years ago, stated "that in no instance had he seen a case in his own practice to which the description of extirpation of the parotid gland was applicable;" and writing more recently, in 1870, he adds, "that when tumors near the parotid are small, that gland is slightly compressed, and when large most of it has disappeared."

Sarcomatous Tumors.—Sarcomatous tumors, in their varied forms, are not unfrequently observed on the face. Fig. 10, taken from a photograph, illustrates a case that was under my care at St. Thomas's Hospital two years ago. After its removal, Mr. Stewart, the curator of the museum, kindly examined the growth microscopically, and pronounced it to be a round-celled sarcoma. The tumor recurred within a year, and in a few months after, the patient died.

Fig. 10.

Another and perhaps rarer form of tumor is the *melanotic sarcoma*, of which I show you photographs. This patient, a man aged sixty-four, was under my care at St. Thomas's Hospital in 1872. He had a congenital mole, which gave no inconvenience whatever for over threescore years. The tumor commenced to grow from the skin quite close to the mole, if not from the mole itself.

The chief point of interest in the case was the probability of its recurrence, for there were several enlarged glands in the right submaxillary region, which I endeavored to remove, but the surrounding parts were so implicated that I was compelled to leave some of the disease. Nevertheless, the patient made a rapid and excellent recovery, and was quite well about a month ago, as I ascertained from his wife, whose letter, dated December 3, 1877, is appended to the photographs I send round. There has, therefore, been no return of the disease for a period of over five years.

Sir James Paget, in a lecture on tumors in connection with moles, refers to a case of somewhat similar character: The patient was sixty years old, healthy all his life, and very temperate, and in the site of the tumor there had been a mole as long as he could remember; it never gave him any trouble until about nine months previously, when, with some tingling, it began to enlarge, and continued to do so up to the time of his admission. Liston refers to another case in a patient aged forty.

Hypertrophy.—Hypertrophy of the integument of the nose —the lipoma of some writers—is not unfrequently observed. The growth appears to be an excess of the fibro-areolar tissue with some enlargement of the sebaceous glands. Many cases of the kind are on record, but one remarkable instance is reported by Mr. Pollock. The patient was a woman aged seventy-three, and the growth was eight inches in circumference, being the shape of an ordinary pear.

In very rare cases the external ear or pinna undergoes hypertrophy, but generally the enlargement is only temporary, and is due to the inflammatory thickening of the part. Boyer, however, met with a genuine case of hypertrophy, in which the ear was so large that it covered a great part of the cheek.

Horny Growths.—Horny growths occur on different parts of the face. They either consist of epithelium in various stages of dryness, or they may originate in the sebaceous follicles by a continuous proliferation of their epithelial contents. Mr. Canton describes a good example on the upper eyelid, and

Mr. Cock, of Guy's Hospital, another instance on the lower lip. And a third and still more interesting case is recorded in the Pathological Transactions by Mr. Charles Roberts, of York. The growth was taken from the face of a woman, aged seventy-five. And, lastly, this specimen of a horny growth from the museum of St. Thomas's Hospital is of considerable interest. The growth measured ten inches in length, and was removed from the upper part of a man's head.

Carcinomata.—The epithelial form of cancer is that most frequently observed on the face. It attacks the nose or the cheeks and lips, and relatively by far most frequently the lower lip. Sir Astley Cooper stated that, of two hundred cases that he had seen of this disease, in only one was the upper lip the seat of the affection. It is essentially a disease of adult life, for Lebert states that, of seventeen persons upon whom he operated for this disease, two only were under the age of thirty-five; and M. Fleury, of Clermont, observes that between 1845 and 1855 he had operated on eighty-six patients, seventy-one being men and fifteen women, and not one of them was less than forty-three years of age.

To show the comparative frequency of epithelial cancer, Mr. Erasmus Wilson remarks that, of two thousand cases of cutaneous disease, epithelioma occurred eleven times; in other words, about one in every two hundred. In twenty cases it was more than twice as frequent in males as in females. In two-thirds of that number it occurred after the age of fifty, several of the patients being above sixty, and its general duration at the time of coming under treatment ranged between two and fifteen years. In all the twenty cases the disease manifested itself on the face or its immediate neighborhood; in nine it appeared on the cheek; in eight upon the nose; while in one case it was developed on the eyebrow near its outer extremity, in another on the temple, and in a third upon the mastoid process.

Tobacco smoking is alleged to be a common cause of epithelioma of the lip. Roux held this opinion, but Fleury noticed the remarkable fact that all his patients came from a district where smoking was almost unpracticed.

Colloid cancer of the face appears to be very rarely met with, but one example occurring in the upper lip is recorded by Mr. Curling. The patient was a young man, and the growth had existed for five months. Dr. Andrew Clark examined the specimen microscopically.

One of the specimens on the table is a section of a skull projecting into the cavity of which is an encephaloid growth. It was taken from a patient from whom the parotid gland had been removed by Mr. Solly for encephaloid disease.

I regret that time will not allow me to enter fully into the different diseases of the jaws, although I fear that I could add but little to what Mr. Heath has published on the subject; but the tumors connected with these and other bones of the face may, I think, be reduced to a very simple classification. Thus:

FIG. 11.

1. We have cysts in the upper and lower jaws, of which I show you specimens from St. Thomas's Hospital Museum; and Figure 11 illustrates one form of such diseases, that in the lower jaw, the case having been under the care of Mr. Royes Bell.

2. There are the fibromata, or fibrous tumors, which usually spring in the upper jaw from one of two situations: either the interior of the antrum, or some portion of the alveolus. They are the commonest form of growth in the lower jaw. Cysts may be superadded to the fibrous structure, as in this case, of which I show you a photograph, of fibro-cystic disease involving the palate bones and palatal processes of both superior maxillæ. Mr. MacCormac was kind enough to allow me to take charge of this patient.

3. There are the different forms of sarcomatous tumors. Here are photographs, taken before and after operation, of a patient from whom I removed a spindle-celled sarcoma in April last. The tumor apparently commenced in the roof of the mouth, and subsequently implicated the antrum. An incision was made in the middle line of the upper lip, and the whole of the superior maxilla, excepting the orbital surface, with a considerable portion of the soft palate, was removed. [This patient was exhibited to the Fellows.]

4. There are the enchondromata, or cartilaginous tumors.

5. The osteomata, or bony tumors.

6. The carcinomata, of which the medullary or encephaloid cancer is the most common variety, although cases of scirrhus are recorded as involving both the upper and lower jaws.

7. Lastly, there are the vascular tumors.

A brief reference may now be made to the preliminary skin incisions which are generally employed at the present day in removing tumors of the upper jaw. Sir William Fergusson seems to have perfected the planning of these incisions, and I imagine that few surgeons would now think of gashing the cheek from the angle of the mouth to the external ear. Before applying the knife to the skin of the face, the surgeon should be quite sure that an incision is absolutely required, for many growths of small size, and cysts connected with the upper and lower jaws, may be operated on through the open mouth, without cutting the lip. Assuming incisions to be necessary, a considerable and often sufficient amount of room is afforded by dividing the upper lip exactly in the median line, carrying the wound into one or both nostrils. If more room is required, a second incision may be made upwards along the side of the nose, at the junction of the ala with the cheek; and a third may, if necessary, be employed, extending in a horizontal and somewhat curved manner under lower eyelid towards the zygoma. After the diseased part has been removed the cut surfaces may be united by the ordinary interrupted suture made of silk, which seems to me to be preferable to silver wire. In closing the lip, some surgeons use

harelip pins and the twisted suture, but I fail to perceive that this plan possesses any advantage over the ordinary interrupted suture.

Dieffenbach seems to have been fully alive to the importance of not disfiguring the patient unnecessarily. Thus, in a paper on Resection of the Facial Bones, published in 1838, he says: "I began the operation by dividing the face in the median line, commencing between the eyebrows, and extended this incision downwards to the nose and upper lip; I then made a transverse incision parallel with the aperture of the eyelid, and separated the soft parts—*i. e.*, half the nose, the lower eyelid, the upper lip, and the cheek—from the tumor, and turned back the flap towards the ear." He adds that, by dividing the face along the median line, "I have suggested a new method of operation, the effect of which is to prevent the paralysis of one side of the face, the infallible consequence of commencing our incisions on the posterior part of the cheek."

Respecting operations on the lower jaw, I need only add that, if incisions are required in the skin, they should be so planned as to leave as little scar as possible.

The removal of tumors involving the greater part of the upper and lower jaws, by the subperiosteal method, has been practiced by Langenbeck, Signoroni, Ollier, von Pitha, and other continental surgeons; and cases are reported by Messrs. Bryant, Maunder, Quinlan of Dublin, Barwell, and others in this country.

Nævus.—Nævus is not unfrequently found in the face, and, when of rapid growth, may cause great disfigurement. It is met with, first, either as the cutaneous variety, as in this instance, situated on the ear (Fig. 12.) Secondly, it may be subcutaneous, and not involve the skin, when it is generally observed above the lips (see Fig. 13), on the cheeks, and over the parotid region. Or, thirdly, it may be of the mixed kind.

Nævus seldom produces displacement of the neighboring bones. Mr. Bryant, however, describes a case in which a nævus of the lip flattened the teeth of both jaws.

is not unusual to find two or more nævi on the same pa-

tient. Mr. Croly, of Ireland, reports a case in which there were four distinct nævi, one situated on the lower lip, a second in the right parotid region, a third at the back of the neck, and a fourth on the tongue. A still more remarkable instance is recorded of symmetrical nævi, the size of a sixpence, occurring in twins, male and female, eight years of age.

The question of operation is one of some importance, and before the surgeon proceeds to effect a radical cure, and thus perhaps produce a permanent cicatrix, he should not forget that many nævi disappear without surgical interference. The cutaneous nævus is especially the variety to which this remark applies. I do not think there can be a doubt that some nævi do wither away spontaneously, for they are very rarely met with in the adult.

FIG. 12.

FIG. 13.

With regard to the radical cure of nævi, I need not occupy time by referring in detail to the various methods of treating such tumors, whether by the application of continuous pressure, or by the actual or other form of cautery, or by obliterating the neighboring vessels by acupressure, as in a case reported by Mr. Bellamy, or by enucleation, as advocated by Mr. Teale, of Leeds, or by the use of the galvanic current, styptic injections, etc., but will conclude this lecture by alluding to some of the more complicated methods of applying the ligature.

Practically, these methods resolve themselves into two classes: First, those in which the skin is not included, a very important consideration when the nævus is situated on a conspicuous part, such as the face; and, secondly, those in which the skin is included.

FOREIGN CORRESPONDENCE—OUR LONDON LETTER.

LONDON, March, 1879.

MY DEAR YANDELL: The claims of the American Practitioner are again forcing themselves upon my attention; and I begin to realize that months after all pass quickly in other matters over and above paying one's rent. Still the pleasure of writing to you is sufficient to make one, in one sense at least, grateful that months are fleeting.

Knowing the interest you take in antiseptic surgery, especially in relation to the abdominal cavity, it is probable the communication made by Dr. Matthews Duncan to the Medical Society lately on Antiseptic Midwifery will best please you; so I shall give you an abstract of it. Among the different causes of puerperal septicemia, the poisoning of the patient from within herself, or by the hands of the accoucheur, is the most common. Antiseptic midwifery strikes directly at both these sources of danger, and, Dr. Duncan thinks, will reduce puerperal mortality more pronouncedly than all the other modern improvements put together. So far as he spoke that evening he engaged himself solely with the consideration of local treatment, and left out by design any review of the antiseptic treatment of the blood by the administration of antiseptics by the mouth. He proceeded to say that the nose usually furnished sufficient evidence of the putrefactive condition of the lochial discharge, but pointed out that the lochia of some women possessed an odor approaching that of putrefaction without being at all putrid. As to the mode of production of puerperal septicemia, he thought the putrefying liquor sometimes flows steadily into the circulation from the uterine sinuses into the veins of the broad ligaments; while at other times it is taken up by the lymphatics. The first thing to be done is to remove all decomposing material from the uterus and vagina by finger or forceps, if possible. If the putrefying substance be beyond reach by these means, and an intra-uterine antiseptic lotion thoroughly applied does not stop the putrescence, then an attempt should be made to introduce the carbolized hand to find, and if possible remove, the offending material. Then the vagina and uterus should be thoroughly washed out with the greatest care, and with the gentlest pressure that will be effective. In order to

secure gentleness of pressure, it is necessary to have a free exit for the fluid; and in order to secure this a double tube is essential. As to the pressure it could be procured from a basin of the injection fluid, held not too high, and a tube to the uterus. The instant the outflow is arrested, the injection must be stopped. It should be continued until the return fluid is quite clear. Such an antiseptic fluid could be made by a one in fifty carbolic acid solution, the lotion being lukewarm when used. The tube might be left *in utero* for a short time, but the idea of leaving it there continuously as a drainage-tube he reprobated, pointing out that such a tube would be a source of danger if not antiseptically plugged, and if so plugged it no longer was a drainage-tube. He did not think intra-uterine injection absolutely free from danger, and therefore the irrigation should not be unnecessarily repeated; and he thought about half a pint of the antiseptic fluid sufficient for each irrigation.

The dangers of such irrigation were confined exclusively to the irrigation of the uterus. The danger of propelling the intra-uterine lotion through an open fallopian tube had been demonstrated as a possibility. Such danger, however, is very small, and the chief danger is from poisoning. Such poisoning as only goes to the extent of producing dark-colored urine need not produce alarm. Serious poisoning might produce shivering and cyanosis, with a fast, weak pulse, and then the use of the lotion must be abandoned. Acute poisoning by the carbolic lotion is produced by the fluid finding its way directly into the venous system. The symptoms come on rapidly and resemble those of embolism, and consist of dyspnea, insensibility and clonic spasms, with a small and scarcely perceptible pulse. In order to prevent accidents by the lotion finding its way into the uterine sinuses, Dr. Duncan advocates the administration of ergot on the one hand, and the exercise of the greatest caution in irrigating the uterus on the other. At times hemorrhage follows the irritation, but this is usually the result of carelessness in the management of the irrigation.

Then Dr. Duncan proceeded to discuss antiseptic midwifery from its prophylactic side. This is undoubtedly the most interesting aspect of the subject. In the first section of the paper, the management of a case of established puerperal septicemia was discussed; in the latter section the prevention of such an untoward accident, by the adoption of antiseptic precautions, was reviewed. He did not support the view of conducting confinements under the spray.

For the application of the Listerian method to midwifery, it would be necessary to procure preliminary disinfection of the vagina and cervix uteri; then the confinement would have to be carried on in the face of the fact of the near proximity of the anus as a source of danger. He thought that the Cesarian operation could not be carried out antiseptically so completely as ovariotomy could, because the natural orifice was a source of danger, and propagation of sepsis from or by the vagina was readily attained. The disarrangement of the sutures by the uterine movements would also interfere with the plan of treatment. Already in a number of the maternity hospitals of the Continent the use of antiseptics has greatly reduced the mortality, and the introduction of the plan into private practice promises to do much to save life. In the Royal Maternity Hospital of Edinburgh, what may be called carbolic precautions were used in addition to ordinary cleanliness. All washings of the pudenda are done with carbolic water. Consequently the sponges and the hands of the attendants are consequently kept antiseptic. The ointment used in vaginal examinations is carbolized. Physicians and students alike wash their hands in carbolic lotion. In Basle, a three per cent. lotion is used for the hands, and a ten per cent. ointment for anointing the finger, or the hand or instrument, if the latter be used. All lacerations are sutured, and a dossil of charpie, soaked in ten per cent. oil, is placed in the vaginal orifice, and renewed as often as it falls out, or after urinations or injections. These precautions are used for twelve days; the injections, of a two per cent. lotion, being made twice daily. The importance of free evacuation of the lochia is also insisted upon.

Dr. Duncan then proceeded to consider the conveyance of infection by nurses or doctors. The adoption of antiseptic precautions ought to produce something approaching absolute assurance of safety; and the medical man can quickly make himself medically clean in hands, person and dress: he should, however, avoid undertaking the duties of nurses, and of using the hands in post mortem investigations. Then, as to the last subject—danger from within—he is opposed to the use of intra-uterine injections in natural cases; and the leaving of a drainage-tube in the passages will be, he thinks, a source of danger. He holds that it is doubtful if ever the danger from within arises spontaneously, but is always, or almost always, imparted from without, and that too even in the presence of an epidemic. Still Dr. Duncan does not hesitate to secure evacuation

of the uterus when lochia are retained, and to use antiseptic cares if there be any discernible occasion for them.

Finally, comes the antiseptic management of the child; and for it the same prophylactic and therapeutical antiseptic cares are as valuable as for the mother. The child is liable to infection through its umbilical cord, either from ulceration or the cord becoming putrid. The delicate organism of the child is much more easily poisoned than the more mature system of the mother. Consequently antiseptic dressing of the cord is a matter to be carefully attended to.

Prof. Rutherford, of Edinburgh, has concluded his report on the action of cholagogues, conducted for the British Medical Association. After having given his experiments, performed by himself and his assistants, as to the action of ipecacuanha, salicylic acid, chloride of ammonium, etc., he concludes by comparing the information furnished by clinical observation and physiological research into the action of drugs upon the liver, and in the formation of bile. He showed how difficult it was in man to determine betwixt the "secretion" and the "discharge" of bile. Certain purgative agents, like sulphate of magnesia and castor oil, which stimulate the intestinal canals, actually diminish the amount of bile. He is very much inclined to hold the view that ipecacuanha is of service in the treatment of dysentery from its action upon the liver, and that the presence of bile in the intestines affects them favorably. He finds there are direct hepatic stimulants, and direct hepatic depressants; that is, agents which increase the activity of the liver, and those which diminish its activity. Of course he is careful to point out that results attained by experimentation on the dog must not be applied directly to man; but says that the information afforded by such experimentation is useful in explaining the results attained by clinical investigation. Thus the experiments made as to the action of calomel, show that there is no real discrepancy between the observations of the physiologist and those of the clinical observer, who knows that its administration is followed by an increased discharge of bile. As to the introduction of the different substances, experimented upon, into the duodenum of the dog, whilst they must be given by the mouth in man, Prof. Rutherford says, if our results had not been in harmony with clinical experience, then it would have been permissible to harbor suspicions as to the value of the method adopted. He ventures to hope that they have laid the

foundation of a rational, that is a scientific, treatment of many of the diseased conditions of this organ, by the light thrown upon the action of certain remedies on the liver; and concludes by an eloquent defense of the aims of physiologists from the bitter and virulent attacks made by the clamorous rage of sentimentally inspired ignorance.

I may, perhaps, be permitted to conclude this letter by a quotation from the Hunterian oration, recently delivered by Professor Humphry, of Cambridge. He says:—"What is really wanted, and what teachers and examiners must combine to promote, is, to use the language of the 'laughing philosopher,' Democritus, who was one of the greatest thinkers of antiquity, that 'we should strive, not after fullness of knowledge, but fullness of understanding;' that is, that we should strive for good, clear, solid, intelligent, producible and available knowledge of the kind that will be useful in after-life; not so much the refinements of chemistry, anatomy and physiology, which, in their aggregate, are likely to perplex, encumber, stupefy, and then pass away like chaff before the wind; but the essential, fundamental facts and principles welded together, and so woven into the student's mind that he can hold them firmly and wield them effectually; and that he is conscious of them, not as the goods of other men, or as dogmas which he has because they were imposed upon him, but as his own possessions, of which he appreciates the value because he knows how to use them. 'The knowledge that a man can use is the only real knowledge, the only knowledge which has life and growth in it, and converts itself into practical power. The rest hangs like dust about the brain, or dries like rain-drops off the stones.' (Froude: Short Studies on Great Subjects.)"

Surely Froude had had the present medical education in his mind's eye when he penned that pregnant sentence.

J. M. F.

Reviews.

Diphtheria — Its Nature and Treatment, Varieties and Local Expressions. By MORELL MACKENZIE, M. D., London. Philadelphia: Lindsay and Blakiston. 1879.

This is a neatly printed duodecimo volume of one hundred and one pages. From the author's position, ample experience, and special line of study, we naturally expect that what he sees fit to write about will be written well, and that he will furnish us with the latest and best digested data upon the subject in hand. Our anticipations in this regard are more than realized in the work before us. It is not claimed to be an elaborate treatise upon diphtheria; and while we can not conscientiously say that the work furnishes us anything in the way of novelty or originality, we must admit that we have never seen its equal as a full, fair, concise and honest résumé of the subject concerning which it treats. A perusal of this, the latest of Dr. Mackenzie's lucubrations, will hardly occupy two hours, and we guarantee that they will be two hours very profitably spent. We find in it a condensation of all the known facts concerning diphtheria, as regards its history, etiology, pathology and treatment; due prominence being given to what is positive and practical, but little attention being bestowed upon what is purely theoretical and conjectural. We are given the very gist of the subject in the fewest possible and plainest words. We are presented with the kernel and the fruit ready prepared, without being called upon to delve through the shells and the husks wherein they may lie concealed.

The work is divided into twelve chapters: Chapter I is devoted to the definition and history of Diphtheria; Chapter II to Etiology; Chapter III to Symptoms; Chapter IV to Paral-

ysis incident to Diphtheria; Chapter V to Diagnosis; Chapter VI to Pathology; Chapter VII to Prognosis; Chapter VIII to Treatment; Chapter IX to Laryngo-Tracheal Diphtheria (or Croup); Chapter X to Nasal Diphtheria; Chapter XI to Secondary Diphtheria.

The history of diphtheria is given succinctly, and develops satisfactorily the conclusion that far from being a modern affection, it can be traced away back into the dim ages of the long past. It is almost as hoary in its antiquity as the leprosy of biblical fame. "A rose by any other name will smell as sweet." If the disease was not known under its present fancy title, as many households were robbed of their idols by its ravages in the far-distant ages of the past, as they are at the present day. Aretæus was as clear in his account of it, if not as learned, as Bretonneau. The Talmud and Old Testament give as faithful a portraiture of this scourge, for all practical purposes, as do Ziemssen and Flint. A careful perusal of this portion of Dr. Mackenzie's monograph will amply repay any one interested in this kind of research. Step by step the onward march of diphtheria is traced from ancient to modern times. Its varying degrees of severity as to times and places is concisely stated, and powerfully impresses one with the thought of how much havoc this disease has spread in days gone by, and how much it is capable of in those to come.

The chapter on etiology is full and accurate, and gives, as far as known, all that concerns this branch of the subject. The exciting cause of diphtheria is a specific contagium. Cases which seem to originate *de novo*, if followed out can always be traced to previously existing ones. As a strongly predisposing cause of diphtheria, tender age plays a prominent part. The accidental existence of pharyngeal catarrh, or of any disease which lessens vitality, increases individual receptivity. Family constitution also has an unfavorable influence. Just right here we might remark that in our own experience — not by any means limited — we have never seen a case of genuine diphtheria in a perfectly healthy child, and one entirely clear of strumous taint. To our thinking struma

must never be left out of view as one of the essential determining causes of diphtheria. The contagious principle of diphtheria has not been isolated. It is probable that it consists of small particles of matter floating in the atmosphere—call them what we may, fungi or bacteria. The author considers the germ theory of diphtheria *adhuc sub judice*. While low vegetable organisms may possibly play an important part in the propagation of the disease, their exact relationship has not yet been fully made out. The observations of Oertel, Hueter, Letzerich, and others, only show that micrococci are invariably attendant upon diphtheria. The relation of cause and effect between the two has not been demonstrated: while bacteria can always be found in and around diphtheritic deposits, that they are the sole, or even the main agents in the causation of such deposits, yet remains to be proved.

Inasmuch as the disease so often arises in connection with bad drainage, foul habits and impure water supply, and as it is often impossible to trace the remotest channel of contagion, these facts lend color to the idea that diphtheria can and does originate *de novo*. But the whole tendency of modern teaching and sanitary science combat the doctrine of spontaneity in the origin of specific diseases. It must be borne in mind that in those instances where the disease seems to enter the system through foul drainage or drinking water, the specific germs of diphtheria derived from persons previously the subject of it may have found their way into these channels of contagion. Various instances are given by the author, where these difficulties of tracing the disease to its source presented themselves, but which were surmounted by careful investigation into the facts.

Diphtheria prevails in every country, but is most common in temperate climates. Its material of contagion lives under ordinary atmospheric conditions, but *dampness* favors its development. It is found in the tropics, but it has not been noticed in the Arctic regions. The germs of the disease may lie dormant external to the body for a considerable length of time, and may only develop into activity under the stimulus

of some peculiar atmospheric condition, or when a suitable nidus presents itself. The author has known the poison to thus remain dormant for four, seven and fifteen months, and in one instance for three years, and then to become active. In Great Britain diphtheria has been more prevalent in parts where the rainfall is great, in valleys, or in points where the surface drainage is defective; but at the same time it has shown great epidemic persistency in high, dry, and exposed situations.

The disease seems to prefer rural to urban districts. The author quotes authority for the statement that the number of fatal cases of diphtheria in the rural districts is nearly three times that in urban portions of the country. He hazards the suggestion that those conditions which seem to promote fungoid growth would appear to favor the incidence and persistence of the disease. The comparative immunity of towns from the prevalence of diphtheria as compared to the country, may be traced to the presence in towns of something in their atmosphere inimical to fungoid growth.

Formerly the extension of diphtheria was considered to be independent of seasons, but the weight of testimony tends to show that it prevails more extensively during the winter months than at other periods of the year. Many epidemics, however, have steadily raged throughout the whole year, in spite of the most varied atmospheric changes.

As regards the mode in which the diphtheritic poison is diffused opinions differ. Direct contagion from person to person must be rare, inasmuch as it is extremely difficult to effect artificial implantation of the deposit. This fact would seem to indicate that the contagion, when set free from an affected person, undergoes further development (as in the case of cholera and typhoid fever), which increases its morbific properties. Cases have been reported in which the poison has been conveyed by a person not actually affected by the disease. That it is portable through the agency of fomites can not be doubted. When the disease exists endemically or sporadically, the contagion does not assume a virulent form, and proper hygienic

measures are invariably successful in confining it to a limited area. The distance at which the contagious principle of diphtheria can operate is, as a rule, more limited than is the case in typhus or variola. Under other circumstances, as when diphtheria is epidemic, the contagion is highly virulent and may be wafted over extensive tracts of country. The poison of diphtheria may be transmitted from one person to another, first, by direct implantation of the germs in the deposit; second, through the circumambient air; third, through the water that is drank or the food that is eaten; fourth, it is possible that the poison may be introduced by inoculation, either with portions of false membrane or with the blood of an infected subject. The period of incubation is very short, generally from two to three days, but it may occasionally be for so long a period as two or three weeks.

The most obvious predisposing cause of diphtheria is age. In an analysis of seventy thousand fatal cases contained in the returns of the Registrar General, children from one to five years of age gave four hundred and fifty in one thousand; those from five to ten years gave two hundeed and sixty in one thousand. As age increases the ratio diminishes. In the Florentine epidemic of 1872–73, in fifteen hundred and forty-six cases, in only fifteen were the patients over thirty years of age. While the disease very rarely attacks children at one year of age and under, such is not always the case. Cases have occurred in which very young children at the breast have suffered from it.

Social position has but little if any influence on the distribution of the disease. While it is true that in its endemic form those who are so situated as to be surrounded by proper hygienic regulations are rarely attacked; nevertheless when the disorder is widespread and epidemic, these latter favorable conditions seem to be of no avail against its inroads. Statistics from various authorities tend to demonstrate that during an epidemic of diphtheria no importance is to be attached to the hygienic condition of a locality as a cause of the malady. Nnmerous are the instances in which many persons have fallen victims to diphtheria who lived in affluence, and in lofty, well

ventilated, and in all respects salubrious dwellings. When diphtheria becomes epidemic in a locality an elaborate system of drainage or sewerage may be the means of disseminating the poison, as sewers and water-closets afford a ready means of contaminating the surrounding air and drinking water. From this it is not difficult to understand why the poorer classes may escape a danger which the wealthy are threatened with from the nature of their luxurious conveniences.

During the existence of an epidemic the accidental occurrence of a catarrh seems to attract the specific virus to the throat, and people the subjects of enlarged tonsils and relaxed throats are specially liable to contract diphtheria. The latter fact seems to point to struma as a strong determining cause, as we have before remarked. One attack of diphtheria probably affords a protection—though a very slight one—against recurrence.

In treating of the symptoms of diphtheria our author is particularly happy. No hurried summary can give anything approaching a full measure of justice to this portion of the work—and luckily such an attempt is not necessary to any practitioner who has been so unfortunate as to have seen much of this terrible malady. When at all virulent it tells its own story with no uncertain sound. Its symptoms vary in different cases from those of quite a slight sore throat to those of the most malignant blood poisoning. The presence of the "false membrane" in the throat is the characteristic symptom, but in slight cases the disease may subside before its formation becomes decided, and occasionally the patient dies before it is developed. In some cases there is decided inflammation, while in others there is scarcely a trace of it.

Dr. Mackenzie divides diphtheria into six different constitutional forms,—first, the typical form; second, the mild or catarrhal form; third, the inflammatory form; fourth, the malignant form; fifth, the gangrenous form; sixth, the chronic form. All of these forms may run into one another, or their special features may be more or less combined. The differences dependent on the site of the affection are,—(*a*) nasal diphtheria; (*b*) laryngeal diphtheria or croup.

This review would occupy too much space were we to attempt to summarize the author's exceedingly lucid account of the symptoms attendant upon the various forms of diphtheria. A just estimate of how he has accomplished his task can be found only by an attentive perusal of his admirable monograph.

To the various paralyses incident to diphtheria a special chapter is devoted. This portion of the work accords fully with the others in clearness and conciseness. Statistics and researches collected from various sources show that paralysis of some sort is attendant upon diphtheria in about 10 per cent. of the whole number of cases. But this proportion varies considerably in different epidemics. The kind of paralysis is also varied. It may be partial or complete—may limit itself to single groups of muscles, or may involve the whole voluntary muscular system. The advent of paralysis is always gradual, and as a rule it occurs during the second or third week after the complete disappearance of the local lesion. Paralysis may however occur, though rarely, before the disappearance of the false membrane; on the other hand, it may be delayed as late as the sixth week of convalescence. Its advance is gradual, and it may continue to extend for weeks after its first appearance. The muscles most commonly affected are those of the soft palate and pharynx, of the eye and the extremities. Paralysis of the larynx is an occasional occurrence, but is much less common than the other palsies. Recovery from paralysis following diphtheria, however marked it may be, may almost invariably be counted upon. It disappears in a period varying from six weeks to six months, as a rule, gradually, in the order in which it appeared. The author lays stress upon the danger incident to his cardiac syncope and the extreme debility as concomitants of diphtheria as warnings to the practitioner in the management of his cases, and to the patients as regards undue exertion during or following an attack of the affection. It is possible that a careless practitioner might lose a case of diphtheria without being at all cognizant of its nature. On the other hand we have in our mind's eye not a

few of our craft who are in the habit of calling every case of ordinary tonsillitis and sore throat by the fearful name of diphtheria. The former errs through positive ignorance; the latter is guilty of deception for selfish ends. To both we refer our author's chapter on the diagnosis of diphtheria as eminently worthy of their attention.

The chapter on pathology gives an admirable résumé of all that is known at the present day concerning the nature of the disease in general—the special "false membrane," the local complications, the cardiac syncope, the paralyses, and the morbific impress which diphtheria has upon special organs and systems.

The mortality of diphtheria varies chiefly according to the age of the patient, the character and stage of the epidemic, and the parts involved. The relative proportion of deaths to cases is not at all constant. In some epidemics the death rate has exceeded 50 per cent. The dangers most to be feared in diphtheria at the outset are, on the one hand, extension of the disease to the larynx, and on the other severe blood poisoning. In the one case the patient may die rapidly from asphyxia, and on the other from collapse, or may rapidly sink with typhoid symptoms. At a later period a fatal result may be brought about by repeated attacks of syncope, by general prostration without manifest cause, by constant and uncontrollable vomiting, by severe hemorrhages, or by inflammatory complications, such as pneumonia or nephritis. Death during apparent convalescence may be caused by paralysis of the heart or the inspiratory muscles, from intercurrent disease of the lungs and pleura, or from general failure of nerve force. As a general rule the most trustworthy data upon which to form a prognosis in diphtheria are those which relate to the character and mortality of the prevailing epidemic. The author states as a rule that of the cases in which a definite false membrane is present, one-third, at least, will probably prove fatal. As stated before, the more the disease attacks young children, all the more may we expect death to be the result. The special symptoms upon which to found a prognosis in any

given case are: high temperature, extreme prostration, hemorrhages, and urgent vomiting. These are symptoms which point to extensive general infection, and are of very grave prognostic import. The prognosis is bad in proportion to the thickness and extent of the false membrane exudation. When the exudation seems disposed to extend rapidly the danger is considerable, as such extension is most likely to produce asphyxia by blocking the larynx and trachea. Albuminuria, a very common symptom, has no serious prognostic import.

The chapter devoted to the therapeutics of diphtheria is decidedly the best in the book. It is not burdened with a formidable array of authorities, and the author shows a well judged eclecticism by furnishing those views which have best stood the test of time and experience. All treatment of this malady should at the outset be based upon the fact that as regards the general condition of the patient it is the *intensity* of the morbid changes which constitutes the great danger, and that locally the risk lies in *the occurrence of the exudation in a perilous situation.* The limits of this notice will not allow of doing anything more than sketching this portion of the monograph.

As regards the general treatment of diphtheria great stress is laid upon husbanding the patient's strength by food and stimulants, and placing him under the best hygienic influences. The administration of alcohol is regarded as almost always advisable. Depletion—local or general—is not to be thought of. Favorable mention is made of Sir William Jenner's plan of always commencing treatment of diphtheria by a preliminary purge of calomel with jalap.

The general remedies for diphtheria which are recommended are: first, the recuperative agents; second, the alleged specifics; third, the antiseptics; and fourth, the expectorants.

Of the recuperative agents iron and quinia are most entitled to consideration. The tincture of the perchloride of iron is the agent preferred, and should be given with no sparing hand. High temperature, headache, vomiting, and other symptoms of septic poisoning, are the main indications for the salts of bark.

Of the alleged specific remedies mercury, sulphide of potassium, bromine, and the balsams of copaiba and cubebs very little is said that could induce one to believe that such remedies are endowed with anything like specific curative action. A trial of them has yielded but negative results.

The general antiseptics include iron, chlorate of potash, carbolic acid and salicylic acid with its compounds. The weight of evidence is still very much in favor of chlorate of potash for its local and general effects. In the general septicemia of diphtheria, carbolic acid and the sulpho-carbolates have proved of service. Salicylic acid and the salicylates are strongly recommended.

The expectorant remedies—senega, ammonia, and the balsams—have not found much favor.

As regards the local treatment of diphtheria, this has varied at different times, and at the present great divergence of opinion exists regarding it. Caustics and astringents, solvents and antiseptics, cold and heat, have each been favored at various times and by various observers. The author, guided by his own and the experience of many others, puts the use of the strong caustics to the throat under the ban of his sharpest protest. They are both useless and injurious. They are useless because they have no effect in contracting the spread of the deposit, and injurious because they give pain and rather aggravate than check the local process.

The astringents, such as tannic acid, alum, and perchloride of iron, each have their advocates. Preference is given over all to the tincture of the perchloride of iron as a topical astringent.

Local agents which act as solvents of the exudate have found no little favor in modern times. The chief of these are lime-water, solution of caustic potash, chlorate of potash and lactic acid. That some of them have a solvent power over the membrane the author sees no reason to doubt. He gives preference to lime-water in the form of spray, and to lactic acid applied to the throat pure with the camel's hair-brush. Lactic acid applied in this way is thought to be the most reliable of all solvents. In most cases antiseptics are very useful.

The best are carbolic acid, permanganate of potash, chlorinated soda, glycerin of borax, and hydrate of chloral. As an antiseptic local application, chloral syrup—twenty-five grains to the ounce—is spoken of highly. It is stated that after its use that "whilst it rapidly gets rid of the fetor, it is beautiful to see the membrane loosen and come away, leaving a healthy surface underneath." Whatever antiseptics are used should be administered as gargles or in the form of spray. The local uses of ice and steam, of heat and cold to the throat, are given prominent mention as powerful agents for good—ice in the first stages of the affection, and hot applications in its later stages. Each have their proper place and proper time for use, both of which are aptly illustrated and pointed out by the author.

As a piece of powerful logical reasoning the chapter on laryngo-tracheal diphtheria (formerly called croup), is worthy of special mention. Whatever lingering doubts any one might have as to the clinical and pathological identity of croup and diphtheria will certainly be dispelled by our author's sledge-hammer way of stating the case. That membranous croup is diphtheria we have not the shadow of a doubt. Even should such a doubt have ever entered our minds, Dr. Mackenzie's way of reasoning would certainly woo and win us from it.

We have given some space to a review of this admirable monograph, but its high degree of merit really deserves much more. It should be in the library of every practitioner. To all who wish to keep themselves *au courant* with the vanguard of progress, it is indeed a very gem of the first water.

C. R.

Yellow Fever. By THOS. O. SUMMERS, M. D., Professor of Anatomy and Histology in the University of Nashville and Vanderbilt University. Nashville: Wheeler Brothers. 1879.

Time was when some medical men could, *ex cathedra*, establish theories of disease that would be accepted by the profes-

sion, but that time is passed; to-day no one, however eminent, can promulgate a fresh doctrine and have it received as true and acted on by physicians until it is proven. Yellow fever rightfully claims large attention at this moment, and any observations, whether personal or collated, that are exact and reliable, will find ready appreciation. The author of this monograph details his personal experience, obtained in Memphis during the epidemic of 1878, and the conclusions to which it has led him; but his observations do not have the flavor of exactness, nor his conclusions the tonic inspiration of reliability. For example, this, on p. 12:—"Yellow fever is a zymotic or fermentative disease, and as all fermentation is set up by small organisms, so do all the manifestations of the disease in the human system depend upon the deposit within the blood of living organisms, which in their growth and development produce the morbid changes which characterize the course of the malady." This is an immense declaration, but nothing other than assertion is presented to sustain it: it may be true, but can not be accepted on the *ipse dixit* of any one.

Again, on page 43, speaking of the pulse, this: "Under the finger it is very compressible and rolling, just as though air bubbles were chasing each other along the arterial current, giving rise to the term *gaseons pulse*, the appropriateness of which can only be appreciated by those who have felt the peculiar sensation imparted to the finger. Nor is this a mere *term of resemblance;* for the fermentation in the blood is now at its height, and the carbonic acid *is set free* to such an extent as in reality to fill the current with bubbles." And to this also must be entered the Scotch verdict, "not proven." By the way, may not one appropriately, if not anxiously, inquire how the heart and greater arteries manage to keep these bubbles from accumulating in great bulk, and how the heart and capillaries would act in the presence of a great volume of mephitic air in their interior?

A third quotation is selected from page 9, where the author speaking of the fever, says:—"That it is confined to low, flat regions, has been, by the late fearful epidemic, which has de-

vastated our southern country, forever set aside. That it depends for its existence on the neglect of sanitary measures has been alike demonstrated to be utterly unfounded in fact, and the vaunting boasts of local boards of health who, because living in places not reached by the infection, lay the flattering unction to their souls that they have by any steps taken by them prevented its prevalence, must seem highly amusing to those who have seen its fearful ravages in places remarkable for their natural cleanliness and for their strict hygienic regulations."

Giving to these announcements such place as they seem to deserve in the light of the present methods adopted by leading scientists in investigating and reporting the general and clinical history of epidemics, including their pathology and morbid anatomy, one is forced to the conclusion that the book under notice does not add anything of value to our knowledge of yellow fever.

The typography and general make-up of the volume is not such as to create the idea that the art of medical book publishing has reached perfection in Nashville. J. F. H.

Fowne's Manual of Chemistry, Theoretical and Practical. Revised and Corrected by HENRY WATTS, B. A., F. R. S. Edited by ROBT. BRIDGES, M. D., Professor of Chemistry in the Philadelphia College of Pharmacy. Philadelphia: Henry C. Lea. 1878. 12mo., pp. 1007.

This new American, from the twelfth English edition, has been much enlarged by the revision it has undergone, notwithstanding the fact that the portion relating to physiological chemistry has been omitted. The high standing which this work has always held is fully sustained in the present edition, and Mr. Watts's elaborate revision brings it abreast with the most recent chemical researches. There are one hundred and seventy-seven illustrations. The type is small, but it is better for the sake of convenience that it should be so, than have two volumes as in the English edition.

A New Treatise on Assimilation and Digestion—Showing the different Solvent Juices and Fluids; their Origin and their Uses in the Human System; the Glands from which they are Secreted, and their Realtion to each other. By JOHN WESLEY EVANS, M. D. Quincy, Ill.: Daily Whig Book and Job Printing House. 1878.

A little learning is a dangerous thing, but there may be a degree of littleness that is insufficient to raise the idea of danger, and that excites only pity that a man who promulges that he has practiced medicine for more than thirty years should be willing to publish a book, which, on every page, illustrates not only his lack of learning, but also his want of common sense.

Setting out to enlighten the profession, the author flounders through the fields of physiology in a distressing manner; and on p. 53, produces this astonishing paragraph:—"My theory is as follows: The spleenic* artery conveys the blood into the spleen, which manufactures the gastric juice direct from the blood, and conveys it by a large number of small arteries into the inner coats of the stomach; and those small follicles, or cells, or sacks, that are heretofore mentioned, are merely deputaries* of the gastric juice. So that when food is received into the stomach it is there *readay* to answer the requirements of nature." And on p. 110, this—"The simple structure of the spleen, as we before said, separates the serous from the resamentum* portion of the blood. When the spleen becomes inflamed, and the grape-like appendages of the arteries are congested with cacen* from the blood, there will be a surplus of the blood highly charged with gastratin* in the vena patarum,* and the hepatic artery, and become assimilated by the liver into bile, and then pass into the general circulation, until the system is surcharged with bile and jaundice is the result."

Dr. Evans closes this little volume with a paragraph announcing that this publication is intended to be introductory to another work, on practice, which shall be a detail of his

* Mark the orthography of technical terms. The printers probably kept common words correctly spelled.

experience in over thirty years' labor in that line. If this notice of his present work shall fortunately aid in preventing the issuing of that promised; it will have been instrumental in stopping the press from the production of a mass of crude nonsense, clothed in uncultured diction of inappropriate words used and arranged in utter disregard of the commonest grammatical rules. J. F. H.

Horseback Riding from a Medical Point of View. By GHISLANI DURANT, M. D., Ph. D. New York: Cassell, Peter and Galpin. 1878.

This book sets out to tell how we are made physically and spiritually, and does it after the manner of the ancients, drawing inspiration from Plato, Hippocrates and Galen, Stahl, Boerhaave and Hoffman. Then follows an explanation of medical gymnastics, delineating the nature and value of various corporal motions. Succeeding this is a learned elucidation of horse movements and how they promote the horse-rider's physiological activity, remedy pathological disturbances, and produce hygienic effects generally and superlatively, the whole being a very roundabout, and not particularly attractive nor instructive way of advertising that horseback riding is an agreeable and healthful exercise, a proposition that will be accepted as true without reading the author's pretentious little book.

In the final chapter the author essays to teach that horse-racing was inaugurated by Hercules and his four brothers running a foot-race for a prize, and to drive away *ennui* while lazily superintending the education of Jupiter, a duty with which they had been charged by Rhea. This was a long time ago and far removed from the Bluegrass region, and it might test the powers of the sharpest evolutionist to trace the line of descent to John Harper and his matchless Longfellow.

J. F. H.

PROCEEDINGS OF SOCIETIES.

TRANSACTIONS OF THE CINCINNATI MEDICAL SOCIETY.—At a stated meeting of this society, held February 11, 1879, Dr. William Carson, president, in the chair, the discussion of Dr. Davis's paper on the "Antagonism of Opium and Belladonna" was continued.

Dr. Comegys had not seen many cases of opium poisoning; but in an extreme case which came under his observation, some years since, where the respirations were reduced to three and a half per minute, he employed hypodermic injections of atropia, one-thirtieth of a grain twice, with an interval of thirty minutes, and applied a powerful electro-current during the inspiratory movement, so as to stimulate it to the utmost. Some time after the second injection, on observing that the intensely contracted pupils were beginning to dilate, he felt able to announce that the patient would recover. So extreme was the narcosis that he does not think the electricity would have been equal to saving the patient.

A long time ago, before we had learned to employ remedies subcutaneously, he had occasion to treat a man who was thoroughly narcotized by opium. He gave, in that case, a large dose of tincture of belladonna in starch-water per rectum, and employed artificial respiration for nearly two hours. Here the safety of the patient seemed to have been secured by the latter procedure. That same man afterwards destroyed himself by drinking two ounces of laudanum. He was treated by two eclectic practitioners, by flagellation and forced locomotion, until he about dropped dead. He saw the sufferer, who was really his patient, but the gentlemen, though called in the emergency, refused to surrender the case. He told them how he had been saved before; but they preferred the method they had in hand.

Once, by the error of a druggist, a lady under his charge for a painful affection of the rectum, was pretty thoroughly poisoned by an overdose of belladonna administered in a suppository. He gave her thirty drops of laudanum in brandy, and some more after a short interval. It was with the utmost difficulty anything could be swallowed, owing to the dryness of the throat. The pupils were completely dilated, and there existed a remarkable muscular weakness;

respiration was feebly executed, but the slowness as in opium narcosis, did not exist. It was remarkable that the grave symptoms were produced by two grains of the extract of belladonna.

Opium in small quantities, say two to three drops of laudanum every three hours, stimulates the vassal nerves, and thus increases tonicity of the muscular coat of the extreme vessels; all of the functions of the body are energized, and most agreeable sensations are produced. This is the physiological fact. But by large quantities the opposite state is produced; that is, paralysis of the vasomotor, destruction of vascular tone, the special and general sensibility and tending to death by asthenia. In this state suitable doses, not too large, of atropia offer a strong hope of recovery. The paresis of the blood vessels may be overcome by atropia; but very large doses would only add to the atony already existing. The fact seems to be that both morphia and atropia, in small doses, increase the tonicity of the blood vessels; that in lethal state produced by either, the other in dose to produce physiological effect may be regarded as an antidote. In inflammatory processes, in which there always exists atony of the extreme vessels in the part affected and stasis more or less complete of the circulation, opium may be given (as in peritonitis) in enormous doses with success.

Dr. W. H. Taylor referred to a case, reported by himself to the Society December 22, 1874, of a child three and a half months old that had administered to it one-sixth of a grain of morphia. In a few minutes it began to show evidence of opium poisoning. It was then given three-eighths of a grain of sulphate of atropia. In a short time the full effect of the last-named medicine was established. At this juncture Dr. Taylor was called, and by diligent course of treatment the child recovered. He also referred to a case reported by Dr. Patton (formerly of this city), where rapid narcosis was produced by the hypodermic injection of one half grain of sulphate of morphia, promptly relieved by the injection of one-fifth of a grain of the sulphate of atropia.

Dr. Carson asked Dr. Davis what quantity of sulphate of atropia should be used in a case where respiration was two or three per minute?

Dr. Davis said authors did not agree as to dose; some recommending as small as $\frac{1}{120}$ of a grain, and others as large as one-third of a grain, to be repeated at intervals.

Dr. Carson said Dr. Patton's case had all evidence of full nar-

cosis, breathing two or three times in a minute. He had injected one-half grain of morphia: one-fifth of a grain of atropia was used with good result. If we accept this, what would be a dose?

Dr. Mackenzie had a patient that had taken, by mistake, two grains of atropia. He administered one-half grain of sulphate of morphia hypodermically, which produced no effect at all. He thought the report of the British Commission on the antagonism of opium and belladonna was not well founded. Their experiments were made on rabbits. The fact that these animals have a great tolerance for atropia, would render any evidence derived from that source as incompetent.

Dr. Davis said his paper set forth the physiological effects of opium and belladonna. What constitutes a dose in narcosis, we do not know. We should not overwhelm the patient—should sustain the heart and respiration. Dr. Davis read the following:

Dr. John Harley, in "Old Vegetable Neurotics," after an analysis of twenty-one cases of opium poisoning treated by belladonna, announces the following conclusions:

1. That the evidence of antagonism in any given case is inconclusive.

2. Taken individually or collectively, the cases show that belladonna has no influence whatever in accelerating the recovery from the poisonous effects of opium.

3. The somnolency, stupor, narcotism and coma—the essential effects of the action of opium—are intensified and prolonged by the concurrent action of belladonna.

4. That belladonna is powerless to obviate the chief danger in opium poisoning, namely, the depression of the respiratory function.

5. That the results of the combined action of opium and belladonna are the same, whether given in medicinal or toxical doses. While, therefore, belladonna can not in any sense be regarded as an antidote against opium, but in large doses the exact reverse, it may, under certain conditions mentioned below, and always in very small doses, be used in conjunction with other remedies as a means of aiding the recovery.

The "conditions" referred to are, to give $\frac{1}{60}$ of a grain of sulphate of atropia, at intervals of two hours, to stimulate the failing power of the heart.

Dr. Carson presented a patient suffering with paresis following diphtheria.

Dr. R. B. Davy exhibited a specimen to the Society, and read the following note: Was called a few days ago to see a woman who had been in labor about twelve hours. I was informed by the physician in charge that the membranes had been ruptured and the left shoulder was presenting. Had made several fruitless attempts to turn, and concluded to summon help. Placing the woman under chloroform, I turned and delivered without difficulty.

The child had been dead some time, but was not decomposed. Its encephalic structures were completely broken down, and the cranial bones gave no manner of support to the head. The latter, in fact, was completely without form, and resembled a rubber-bag filled with fluid. The epidermis had almost entirely peeled off, leaving the true skin of a light mahogany color. The cord was about the usual length, turned once around the child's neck, and tied in a knot about its center, tight enough to cut off all circulation. That part of the cord extending from the knot to the child was about the color of the latter's body. The part between the knot and placenta was perfectly black. About half an inch from the child's belly, the cord presented a narrowing the size of a crow's quill. The placenta was apparently unchanged. The woman claimed to have given birth one month before time.

The case is of interest from the fact that the death of the child was evidently caused by the knot found in the cord. The abnormal position of the child arose in all probability from the fact that the head did not present the necessary resistance to dilate the os, and this important part was accomplished by the point of the shoulder.

SESSION, February 18, 1879.

At the Society this evening, the following cases were given in some detail, where before they had been only alluded to, by Dr. Comegys, who procured written statements from Drs. C. O. Wright and Dunlap:

CINCINNATI, February 18, 1879.

DEAR DOCTOR: In reply to your communication, asking for the facts in my case of opium poisoning, and the antagonism of atropia, I herewith furnish you with it, as briefly as possible, presuming this will be all that you desire in this case.

The patient was an infant about ten weeks old, poorly nourished, much emaciated, and suffering with diarrhea. By mistake it took in

mixture about twenty drops of tincture of opium. I saw the case in a little less than a half hour after taking the medicine, and it was then showing the evidences of the opium. You would be surprised at the amount and the strength of emetics I gave it, without the slightest appreciable influence.

In a very short time after my arrival, it became *profoundly* narcotized, and upon examining the eye, it was almost impossible to say there was any evidence of its having had a pupil. It is not necessary to give you the opium symptoms, as they were too plain, and the knowledge of the medicine given was beyond doubt. It was not less than three-quarters of an hour after taking the medicine before I obtained my hypodermic syringe, and I at once injected into the arm a trifle less than a half grain of atropia; and although this was the remedy relied on, other measures were not neglected.

A half hour after the administration of the atropia, the pupil gave slight evidence of its influence, and in one hour it was very decided; from this time on it steadily improved, and I left the case after remaining with it six hours, with the knowledge it was saved, owing to the antagonism of atropia and opium. The child died about a month after this of inanition. Respectfully yours, C. O. WRIGHT.

Dr. W. T. Dunlap furnished the following statement of the treatment of three cases of atropinism:

CASE I. A child aged two years and a half had by mistake (two drachms of a solution of atropia—two grains to one ounce) taken a half a grain of sulphate of atropia. When called in I found the child entirely unconscious, skin intensely red, pupils fully dilated. As it could swallow, I gave one drop of tincture of opium every fifteen minutes. At the end of two and a half hours, I administered hypodermically one-eighth of a grain of sulphate of morphia twice, half an hour apart. After that the pupils began to contract, and redness disappeared gradually. No other treatment was given.

CASE II. The mother, a few days afterward, for a suicidal purpose, took the residue of the solution of atropia—say one and a half grains. I was called four hours afterward. She was unconscious, but very restless, the skin very red, pupils fully dilated; could swallow. I gave at once fifteen drops of laudanum, and in half an hour fifteen drops. I then gave one-third of a grain of morphia hypodermically every three hours. The pupils began to contract after the morphia was given, and redness of the skin disappeared. She was up in twenty-four hours.

CASE III. The patient had taken a prescription, in which, by mistake doubtless, one-fourth of a grain of atropia was an ingredient. Two hours after administration I was called. I found the patient atropinized, pupils fully dilated, skin red, hot and smarting. Gave one

grain of opium every half hour until four grains were taken. Pupils soon contracted, and redness disappeared from the skin. She was able to be about next day.

Dr. Comegys read notes on the cases of opium poisoning which occurred in the experience of Drs. Dunlap and Wright, and afterward said: I can not agree with Dr. Davis that the antagonism between opium and belladonna is so slight; nor can I see why he criticizes the present methods of reporting cases of this kind so severely. Complaints were made at the last meeting that verbal reports were entirely unsatisfactory, and I went to the trouble to see the gentlemen personally and obtain from them the *minutiæ* of the cases. I think it is but fair to say that the gentlemen referred to are reliable even in such delicate matters—as reliable probably as Drs. Wood, Harley, or J. Hughes Bennett, who have been referred to by the essayist. One of the cases occurred within the last four weeks, and not at all likely that it should be inaccurately reported, even if the affair was trusted to memory. With regard to other forms of treatment, as auxiliary to the subcutaneous injection of atropia, being used, I have to say that in Dr. Dunlap's case no other treatment was used, and in Dr. Wright's the child was simply slapped. But with the other treatment usually resorted to, such as slapping, pinching, use of electricity, etc., I can not see how the matter should be so mixed up as to prevent us from noticing the antagonistic effect of atropia.

Dr. Murphy said: It was not my good fortune to hear the reading of Dr. Davis's paper, which took place several meetings ago; but I understand from the discussion to-night that he denies the antagonism of opium and belladonna, or, at any rate, admits it only within a limited range, or so far as it will stimulate failing respiration or a failing heart. I am inclined to think that he relies too much on experimental observations on animals, and lays too little stress on clinical facts. While I have great respect for experimentation on animals, for the purpose of determining the physiological action of remedies, still I recognize the difference between the lower animals and man, and I think we should weigh these distinctions in organisms exceedingly well before we give our decision on this subject. Idiosyncrasies to one or another drug very materially interfere with us in drawing conclusions concerning their action. There is nothing which people fight over more—I mean fight in a Pickwickian sense—than the effects of medicines. I lately gave a man affected

with carbuncle one and a half grains of morphia without producing sleep. Suppose I should decide on the effects of morphia in carbuncle from this one case. My patients would be constantly subjected to the danger of being poisoned. Who, after all, knows anything about the action of medicines? Who can tell how quinia cures ague, or how almost any drug operates after it passes from our view behind the base of the tongue? I remember to have seen one of the cases of opium poisoning referred to to-night. Two students were compelled to hold him up for two hours, to even lift his legs in walking him around. Electricity was used, and he was slapped and pinched in addition to the hypodermic use of atropia; but it can not be said that these were more than auxiliaries to the atropia treatment. I do not wish to take issue with Dr. Davis, or to disparage observations for the purpose of determining the physiological action of medicines, but simply to emphasize the fact that clinical observations are of infinitely more value because they pertain to the human subject. For my own part, if I were to be so unfortunate as to be poisoned by either of these agents, I should direct my attendant to act upon the belief that they are really antagonistic. In cases of such poisoning which come under my hands, I use atropia and morphia, one for poisoning by the other, along with the other means usually applied. This I consider the proper treatment, and shall continue to employ it.

Dr. Illoway said: We have heard from Dr. Davis that opium was but slightly indicated in poisoning by belladonna, and as a proof of the same the treatment was so generally mixed up and confused by the employment of other means, that it was preposterous to attribute the result to the use of opium. In order to meet these statements, I will mention a case which occurred under the observation of Dr. Anderson, now deceased, a resident physician in the Cincinnati Hospital. A man swallowed the contents of a bottle containing eye-water, which was a strong solution of sulphate of atropia. In a short time the characteristic symptoms supervened, and among others the patient's skin was as red as a boiled lobster. Dr. Anderson gave half a grain of morphia hypodermically, and repeated it twice within an hour, and several times afterward. The patient recovered in twenty-four hours, and without other treatment.

Dr. Stanton said: From what I have heard to-night I am inclined to think there is a great deal of truth in the alleged antagonism of these two agents. Poisonous doses of atropia have been repeatedly

given in opium poisoning, without the slightest harm supervening. Let us suppose that there is no such thing as an antagonism between opium and belladonna, would not the doses of atropia invariably given produce poisonous symptoms? Experience shows that they are taken not only without their ordinary physiological effect, but with actual alleviation of the symptoms; and all who have administered large doses of atropia for opium poisoning have exhibited their faith in the procedure, as to do the same under other circumstances would be highly dangerous.

Dr. W. B. Davis said: Atropia in small doses is advantageous in opium poisoning so far as it stimulates the heart and lungs, and when pushed beyond this point it is deleterious. Dr. Stanton forgets the case of Dr. Taylor, where the child was poisoned by opium. The doctor gave a large dose of atropia, and substituted atropia for opium poisoning, which in turn required treatment. In Bartholow's Therapeutics you will find something touching this very point, and care is enjoined on the physician not to overstep the limit. Better repeat the small doses several times than venture too large a one.

In reply to Dr. Murphy, I will say that if more of such cases of poisoning have recovered without atropia than with it, he will readily appreciate the preponderance of evidence in favor of my assertions. We are informed that such is the case, and moreover the observations of Drs. Wood and John Harley show that the atropia treatment is unsatisfactory. I will here refer to the case seen by Drs. Mackenzie, Kearney and Taylor, where the symptoms of atropia poisoning seemed to be intensified by the injection of half a grain hypodermically. My paper is based on the latest observations made on animals, and only expresses the doubts of some of our best thinkers with regard to the alleged antagonism of opium and belladonna.

Dr. Carson read notes on a case of opium poisoning by two ounces of laudanum, Dr. Brown of this city having charge. He was found entirely narcotized. The general plan of treatment was hypodermic use of atropia in comparatively small doses (looking at the recommendations of Fothergill and others),—one-sixtieth of a grain in most of the ten or eleven that were used. The whole amount was not more than one-fourth of a grain. Other measures were used, such as electrical stimulation, coffee, and hypodermic injections of aqua ammoniæ. According to the plan projected by the author of the paper, the clinical position of the antagonizing influences of opium and atropia must be determined by the exclu-

sion of all other measures, or what complicating effects are introduced by such treatment as mentioned above, which renders valueless the inferences drawn as to atropia. The reasoning seems to be incorrect. When a man of experience treats such a case, he has it in his power, more or less, to assign to each remedy used the effect due to it. Our experience with the natural history of opium-poisoning, and with the effect of coffee, electrical stimulus, external applications, etc., enables us to separate with reasonable certainty the several influences brought to bear. In this case there was apparent improvement in the general condition and special symptoms following many of the atropia injections. Such observations, made under the emergencies of practice, are what must settle this question, and not the experimental evidence so freely quoted.

Dr. Comegys reported the case of a man who died at the Cincinnati Hospital of aneurism of the aorta. He said this patient was under observation for three or four months. He suffered intense pain in the sternal region, extending up toward back of neck. I suspected aneurism from the extent of dullness. He had been in the house before, and was thought to have some consolidation of lung. The pulses on the two sides were alike. There was no change in the larynx or pupil of that side, showing that the recurrent laryngeal and cervical sympathetic were not interfered with.

Dr. Dandridge exhibited the aneurism, with heart and sternum, and said: This is mainly an aneurism of the ascending portion of the arch of the aorta, though the transverse portion is also very large. The descending portion is about natural. The arteries are atheromatous, and calcareous plates are to be seen on the internal surface of the enlarged vessel, though not in such abundance as is usual in such cases. This patient was syphilitic. There is universal pericarditis, and the lung is carnified, but the trachea is normal. As I hold the sternum in position, you see a decided prominence a little to the left of the median line, somewhat pyramidal in shape. This marked the site of the tumor in life. As I reverse the sternum and exhibit its posterior aspect, you see that nearly all the bone in this situation has been absorbed on account of pressure from behind; and the aneurism itself was so glued to the bone that pulling them asunder has left this large ragged opening in the anterior wall of the sac. As regards involvement of the larynx, it is said that the respiration had a kind of whistling character just before death.

R. B. D.

Clinic of the Month.

On the Treatment of Lupus by Erasion.—In an article on this subject in the Lancet of February 22 and March 1, 1879, R. Clement Lucas, F. R. C. S., Assistant Surgeon to Guy's Hospital, expresses some surprise that the treatment of lupus by erasion, which has become general throughout Germany, has received so little attention in England. The treatment advocated here is simple, for it requires only that the whole of the diseased tissue should be scraped away by means of a blunt spoon or scoop. To treat the disease effectually, care must be taken to thoroughly eradicate every particle of softened tissue, and there need be no fear of doing too much in this direction.

Those who have no experience in this method of treatment might imagine it possible with a blunt instrument to scrape away sound tissue with the diseased, but so dense is the normal derma that it offers a complete resistance to the scoop, however energetically applied. The operation is painful, and chloroform is necessary during its performance. Volkmann usually brushes the surface over with nitrate of silver after scraping, but the writer thinks this unnecessary. A history of the treatment of ten cases is given. In the first case, a woman twenty-eight years of age, there were five of these brown patches of lupus on her cheeks, varying in size from a sixpence to a shilling.

In order to compare the effects of different methods of treatment, it was determined to excise two patches, scrape two, and apply the galvanic cautery to the fifth. The two smallest were excised by elliptical incisions, and the edges of each wound were brought together by a single suture. She left the hospital a week after the operation, at which time the parts where excision had been practiced looked the most hopeful, as pri-

mary union had here taken place; the patches scraped presented a raw surface with a pale healing edge, and the spot cauterized was also granulating, but with an inflamed areola. A month after the operation the patches scraped had completely healed, the spot cauterized was still unhealed, and the granulations were exuberant, whilst the cicatrices of the two excised portions showed some evidence of the recurrence of the disease. A month later, it now being clear that the disease had returned in the cicatrices of the parts excised, chloroform was administered and these spots were scraped. After this I did not see her again, but I heard from time to time that there was no return of the disease.

The third case cited was that of a cachectic-looking boy, aged nine, who had a large ulcer extending from the temple to the margin of the jaw and from one ear across the nose. It was determined to compare the effects of different methods of treatment on different parts of this large ulcer. Accordingly, caustic potash was applied on one side, nitric acid at another part, and a third part was scraped. In a few days it was evident that the caustic potash had caused a considerable slough; the nitric acid had also burned somewhat deeply, and the healthy tissue near was much inflamed; whereas in the neighborhood of the portion scraped there was no evidence of inflammation, and it was the first to put up healthy granulations. Some months after, when the boy was again seen, considerable repair had taken place. On the inner side, where the caustic potash had been applied, there was now an indurated cicatrix; where nitric acid was applied the cicatricial tissue was less dense; and where the lupus was scraped there was a thin superficial scar. The greater part of the right cheek, however, was still covered with a sore, which was scraped with a spatula until a firm, dense tissue forming its base was reached. In a few days granulations sprang up all over the scraped surface, and with the aid of skin grafting it was soon completely healed. This boy had suffered from lupus during seven of the nine years of his life, and it is doubtful if any other means would have effected a cure, for he had tried a great many remedies.

HEART-CLOT IN PNEUMONIA.—In the New York Medical Journal, April, 1879, is a clinical lecture by Dr. Loomis on the above subject, from which we extract the last paragraph:

You hear from practitioners of medicine, and read in the books and journals, very much about giving carbonate of ammonia (and often in large doses) in pneumonia, with a view of preventing heart-clot. From what I have just said, however, you will readily see that this is all theory. You might as well (and better, I think) give carbonate of ammonia for the purpose of preventing the pneumonia itself as for prevention of heart-clot. If it does any good at all in pneumonia, it is because it acts as a stimulant, and in this way helps the heart perform its work. But as to its preventing heart-clot, I am certainly unwilling to subscribe to any such fanciful opinion. In the history of pneumonia there generally comes a time when we need a diffusible stimulant, and the only question in regard to the carbonate of ammonia is this, Is it the best stimulant at our command? For my own part, I do not believe that it is, and personally I very much prefer to rely upon champagne. When the time comes to give carbonate of ammonia, it is time to give champagne; and the latter, as I have just said, I believe to be much the better stimulant of the two. I trust, however, that no one will misunderstand these remarks in reference to heart-clot. I do not deny that clots do form in the heart in pneumonia, but I believe that this is only the case immediately before death, and that it is not due to any change in the blood itself. I hold, therefore, that it is useless to try to prevent such a thing by the administration of drugs, with the exception of such as act merely as stimulants, and thus increase the power of the heart.

COMBINED USE OF CUTTING AND SPLITTING IN A SEVERE FORM OF STRICTURE.—In the Lancet, March 22, C. F. Maunder, Surgeon to the London Hospital, reports this case:

The patient, aged forty-two, had suffered from stricture for a period of fifteen years. During the first five years of this period the stricture had been split three times, and on each

occasion a relapse followed. During the last nine years voluntary micturition had been altogether in abeyance, and the bladder had to be periodically emptied with a small catheter. Occasionally retention supervened. When this gentleman consulted me, about a month or so ago, I found that the meatus would only admit a No. 9 catheter, and the urine contained a quantity of muco-pus. The first step in the treatment consisted in enlarging the meatus by incision. This I did on February 10th. A week later (the 17th) I divided the stricture anteriorly with Mr. Teevan's urethrotome, and followed it up immediately with Mr. Davy's modification of Holt's instrument, which admits of immediate dilatation up to No. 18. I then emptied the bladder with a full-sized instrument, and the operation was completed. A No. 9 silver catheter was used twice a day, either by myself or by the patient, for two or three days; then Nos. 10, 11, and 12 were gradually substituted to maintain the stricture well dilated. The patient had a tendency to rigors both before and after the operation, but quinia and opium given thrice daily soon checked this. The most gratifying feature in the case is that on the fourth day subsequent to operation the patient micturated voluntarily, an act which he had not performed for the last nine years. My own experience of rapid dilatation by Holt's method for the relief of intractable stricture has been highly satisfactory, the annual passage of a full-sized instrument having been in a very large majority of instances alone necessary. But splitting having failed thrice in this instance, I resolved to try internal incision, supplemented, if necessary, by thorough rapid dilatation. By these means I sought to determine the point at which the stricture should be divided, as well as to limit within safe bounds the extent to which it should be cut.

Notes and Queries.

AMERICAN MEDICAL ASSOCIATION. — The thirtieth annual session will be held in the city of Atlanta, Georgia, commencing on Tuesday, May 6, 1879, at 11 o'clock A. M.

SECTIONS.—"The Chairmen of the several sections shall prepare and read in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective Sections."—By-Laws, Art. II., Sect. 4.

Practice of Medicine, Materia Medica, and Physiology.—Dr. Thomas F. Rochester, Buffalo, N. Y., Chairman; Dr. W. C. Glasgow, St. Louis, Mo., Secretary.

Committees appointed to report to this Section:

On Clinical and Meteorological Records.—Dr. N. S. Davis, Illinois, Chairman.

Effect of Climate in Colorado on Pulmonary Phthisis.—Dr. C. Denison, Colorado, Chairman.

Obstetrics and Diseases of Women and Children.—Dr. E. S. Lewis, New Orleans, La., Chairman.

Surgery and Anatomy.—Dr. Moses Gunn, Chicago, Ill., Chairman; Dr. J. R. Weist, Richmond, Ind., Secretary.

Medical Jurisprudence, Chemistry, and Psychology —Dr. L. M. Eastman, Baltimore, Md., Secretary.

State Medicine and Public Hygiene.—Dr. John S. Billings, Washington, D. C., Chairman; Dr. J. T. Reeve, Appleton, Wis., Secretary.

Ophthalmology, Otology, and Laryngology.—Dr. H. Knapp, New York, Chairman; Dr. X. C. Scott, Cleveland, O., Secretary.

The following Committees are expected to report:

On Prize Essays.—Dr. Robert Battey, Rome, Ga., Chairman.

On Necrology.—Dr. J. M. Toner, Washington, D. C., Chairman.

On Catalogue of National Library.—Dr. H. C. Wood, Philadelphia, Pa., Chairman.

On Recommendations in President Richardson's Address.—Dr. T. G. Richardson, New Orleans, La., Chairman.

On Ozone.—Dr. N. S. Davis, Chicago, Ill., Chairman.

On Sanitaria for Consumptives.—Dr. H. I. Bowditch, Boston, Mass., Chairman.

On Dr. Seguin's paper on the Intervention of Physicians in Education.—Dr. R. J. O'Sullivan, N. Y., Chairman.

Changes in Plan of Organization to be acted upon.

Offered by Dr. J. M. Keller, Arkansas. Plan of Organization, Art. IV., Sec. 1.

In future the Committee on Nominations shall present the name of no person for appointment or election to office or position save on the Committees on Necrology and Climatology, unless the party nominated be in attendance on the Association at the time.

Offered by Dr. H. O. Hitchcock, Michigan. Plan of Organization, Art. IV., Sec. 1.

The several State, Army, and Navy delegations, including delegates and permanent members, shall, on the first day of the Annual Meeting of this Association, at a meeting publicly called for that purpose, nominate candidates for the several offices of President, Vice-President, and Chairmen for the several Sections, and shall choose one of their number to act on the Nominating Committee of the Association, with power to cast as many votes in that Nominating Committee as there are members of the delegation of which he is a member. Candidates for the several offices above named to be reported to the Association shall be selected from the names reported to the Committee of the several State Delegations.

Offered by Dr. A. N. Bell, N. Y. By-Laws: II. Sections.

Consolidate Section 4, On Medical Jurisprudence and Psychology, and Section 5, On State Medicine and Public Hygiene, and call it Section 4.

Offered by Dr. J. J. Caldwell, Md. By-Laws: II. Sections.

Form an additional Section to be known as the Section on Neurology and Electrology.

Offered by Dr. T. Clay Maddux, Md. By-Laws: II. Sections.

Form an additional Section on Diseases of the Genito-Urinary Organs, including Syphilis and Dermatology.

Offered by N. S. Davis, as Chairman of a Committee. "Code of Ethics."

Art. I., paragraph I., add "And hence it is considered derogatory to the interests of the public and the honor of the profession, for any physician or teacher to aid, in any way, the medical teaching or graduation of persons knowing them to be supporters and intended practitioners of some irregular and exclusive system of medicine."

"It shall be the duty of every member of the Association who proposes to present a paper or report to any one of the Sections, to forward

either the paper, or a *title* indicative of its contents and its *length* to the Chairman of the Committee of Arrangements at least one month before the Annual Meeting at which the paper or report is to be read. It shall be the duty of the Chairman and Secretary of each Section to communicate the same information to the Chairman of the Committee of Arrangements concerning such papers and reports as may come into their possession or knowledge, for their respective Sections, the same length of time before the Annual Meeting. And the Committee of Arrangements shall determine the order of reading or presentation of all such papers, and announce the same in the form of a programme for the use of all members attending the Annual Meeting."

WILLIAM B. ATKINSON, M. D.,
Permanent Secretary.

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION.—The following is a list of delegates from the Kentucky State Medical Society:

Dr. H. M. Skillman, Lexington; Dr. J. W. Thompson, Paducah; Dr. J. A. Hodge, Henderson; Dr. J. L. Dismukes, Mayfield; Dr. Turner Anderson, Louisville; Dr. Irvin Keller, Louisville; Dr. H. F. McNary, Princeton; Dr. R. C. Thomas, Bowling Green; Dr. Coleman Rogers, Louisville; Dr. Preston B. Scott, Louisville; Dr. Pinkney Thompson, Henderson; Dr. J. M. Meyer, Danville; Dr. Willoughby Walling, Louisville; Dr. M. F. Coombs, Louisville; Dr. J. Hale, Owensboro; Dr. Harvey McDowell, Cynthiana; Dr. R. W. Taylor, Hawsville; Dr. I. S. Warren, Danville; Dr. A. D. Price, Harrodsburg; Dr. C. W. Kelley, Dr. J. A. Octerlony, Louisville; Dr. S. S. Watkins, Owensboro; Dr. J. D. Neet, Versailles; Dr. H. Brown, Hustonville; Dr. J. D. Collins, Henderson; Dr. J. W. Pritchett, Madisonville; Dr. I. B. Walker, Scottsville; Dr. S. J. Rhodes, South Carrollton; Dr. J. T. Wise, Covington; Dr. J. Baker, Shelbyville; Dr. R. W. Gaines, Hopkinsville; Dr. E. S, Gaillard, Louisville; Dr. D. S. Reynolds, Louisville; Dr. L. S. McMurtry, Danville; Dr. S. R. Craig, Stanford; Dr. R. O. Cowling, Louisville; Dr. John Goodman, Louisville; Dr. D. D. Carter, Versailles; Dr. M. E. Paynter, Midway; Dr. L. P. Yandell, Louisville; Dr. J. M. Holloway, Louisville; Dr. L. B. Todd, Lexington; Dr. W. B. Rodman, Frankfort; Dr. W. E. Ryan, Simpsonville; Dr. J. W. Singleton, Paducah; Dr. W. B. Miller, Calhoun; Dr. J. A. Larrabee, Louisville; Dr. E. R. Palmer, Louisville; Dr. A. R. Vance, Louisville; Dr. P. D. Todd, Eminence; Dr. J. P. Thomas, Pembroke; Dr. D. C. Tucker, Danville; Dr. J. H. Lewis, Georgetown; Dr. C. H. Thomas, Covington; Dr. J. Q. A. Stewart, Frankfort.

OBITUARY.—Willis E. Sutton, M. D., died at the house of his father, Dr. George Sutton, in Aurora, Ind., Feb. 24, 1879. The disease which caused his death, and against which he had struggled for two years, was phthisis pulmonalis. Dr. Sutton received his literary education at Moore's Hill College and Wabash College. He graduated at the Medical College of Ohio in 1872, and the following winter attended Jefferson Medical College. He was a good microscopist, and was the first to detect trichinæ in the pork in South-Eastern Indiana. He was a member of the Indiana State Medical Society, and of the American Medical Association. Dr. Sutton was only thirty years old at the time of his death. He was of a kindly and genial nature, an enthusiastic lover of his profession, and had he lived would have stood in the foremost rank of his medical brethren in Indiana.

Thomas Waddel, M. D., one of the most prominent physicians of Toledo, Ohio, and one of the most promising physicians in the west, died at Toledo, March 9th. He was sick only a few days, and died from congestion due to malaria, aggravated probably by heart complications hitherto unknown. He was one of the editors of the Toledo Medical and Surgical Journal, lecturer on Gynecology in the Toledo School of Medicine, a member of several prominent societies of his own state and of the American Medical Association.

Dr. H. M. Minesinger, Sulphur Springs, Ind., died March 31, 1879. He was a member of the Henry County Medical Society, and a worthy practitioner.

TO ATLANTA FROM LOUISVILLE.—A round trip rate of twenty-three dollars and eighty-five cents, between Louisville and Atlanta, has been agreed upon by the lines interested, in favor of delegates to the meeting of the American Medical Association, to be held at Atlanta, commencing May 6, 1879, and in favor of delegates to the Southern Baptist Convention, to be held at the same place, commencing May 8th, 1879. Tickets will be on sale in Louisville, from May 1st to 6th inclusive, and will be good returning until May 20th inclusive.

PRIORITY IN CHOLECYSTOTOMY.—In a note received from Dr. G. W. H. Kemper, of Muncie, Ind., the priority of this operation is considered as follows:

Dr. W. W. Keen, Philadelphia, reports a case of cholecystotomy, in the American Journal of the Medical Sciences, January, 1879, and on page 139 remarks:—"Originally proposed by Petit and later by Maunder and Hughlings Jackson, so far as I know this is only the second case in which cholecystotomy has been done. The first will be found in the British Medical Journal, June 8, 1878, p. 811." [Sims's case.] It seems not to be known, or else forgotten, that the late Prof. J. S. Bobbs, of Indianapolis, reported a case which was published in the Transactions of the Indiana State Medical Society for 1868, p. 68, entitled "Lithotomy of the Gall-Bladder." Although Dr. Bobbs was in doubt as to the true nature of the case when he commenced the operation, nevertheless the abdomen was opened, the gall-bladder exposed, incised, and the contents (fluid and calculi) removed. This is, if not the first, at least the first successful case on record. The case is unique, and just at the present time, when the operation of "cholecystotomy" is likely to attract the attention of the profession, ought not to be overlooked. I speak to the praise of his memory.

RESIGNATION OF THE PRESIDENT OF THE INDIANA STATE MEDICAL SOCIETY.—Dr. L. Humphreys has tendered, through Dr. Woolen, the secretary of the society, his resignation as president of the Indiana State Medical Society. He does this with extreme regret on account of continued ill health, but resigns at this time that Dr. Newland, the vice-president, may be informed of his action, and be prepared to assume the duties and responsibilities of the presidency.

TO ATLANTA FROM INDIANAPOLIS.—The fare for the round trip, from Indianapolis to Atlanta and return, will be thirty dollars and thirty-five cents. Physicians, whether delegates or not, and their families, can procure excursion tickets: these tickets will be good from the first to the sixth of May, going, and to the twentieth returning.

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APOLLINARIS WATER.—The doubt which some rival dealers attempted to cast on the genuineness of this delightful beverage has, we are glad to learn, been effectually disposed of. The analysis of the water, as conducted by the very first chemists both in England and Germany, and more recently in America, has put the question at rest. The Apollinaris water of commerce is really, as it claims to be, a natural mineral water, delivered to consumers sound and sparkling with the gas of the Brunnen. No greater addition, in the way of a drink, has been made to the comfort of the dyspeptic than this water. As a table beverage it is unsurpassed. To the sufferer from weak stomach and slow digestion it is a blessing. A frequent use of it since it was first introduced into this country, and a bottle or more of it daily last year while in London, leads the writer of this to indorse all that was said of it by Dr. Brunton when it was first used in England. And Apollinaris water is even more than a mere beverage. Of all effervescing drinks, it is the most serviceable in acidity of the stomach, and in the nausea which sometimes follows the use of opium.

TREATMENT OF ASTHMA.—The following comes from Dr. H. M. Smith, of Bloomville, N. Y.:

℞ Lobeliæ fol. pulv., ... ʒ ij
Stramonii fol. pulv., ... ʒ ij
Belladonnæ fol. pulv., ... ʒ ij
Pot. nitrat. pulv., ... ʒ iij.

Mix and keep tightly corked.

I order the patient to shut himself in a small, warm, close room, and sprinkle the medicine upon live coals, or smoke it in a fresh clay pipe, till relief is obtained, which is usually within ten or fifteen minutes.

THE INDIANA STATE MEDICAL SOCIETY.—This society meets at Indianapolis the third Tuesday in May. A large attendance and an unusual number of good papers are promised.